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POOR GEORGE

BY SENTA RYPINS

Few Englishmen and almost no Americans think of George III as a sympathetic character, but across the centuries he appears a pitiful and not unlovable figure. If we are all formed by heredity and environment, George had the cards stacked against him from the start. His grandfather, George II, was a pronounced neurotic, and a good many individuals on both sides of the family were more than a little "queer."

Some of the second George's twists may have originated in his father's intense hatred for him. This father-son enmity was ingrained in the pattern. George II carried it over to his heir, Frederick Louis, whom he called a nauseous little beast, and who died, not much regretted by anyone, at the age of 44, leaving his own 12-year-old son, the third George, heir to the throne. This was in 1750.

George was brought up by his mother, with the assistance of her friend, Lord Bute. Compared with the careful training given only a little later to Victoria, George's education was stuffy and inadequate. His tutors did not teach him anything that would ever be of much use to him. From his mother he got the injunction: "George, be a king!" and he came to grief repeatedly trying to live up to it.

Left to himself, he preferred the pursuits of the ordinary English squire. In fact, had he been born a simple gentleman he might have been perfectly happy. Country life and farming appealed to him. He was obsessed with outdoor exercise: A 12-mile walk was nothing to him; he wore out his horses with hard riding. He liked fireworks and enjoyed a practical joke. On the other hand, he took an interest in mechanics, architecture, books and painting. In his later years he was a patron of the astronomer Herschel, and collected one of the finest private libraries in the kingdom. He read a great deal, mostly on devotional subjects, for religion went deep with him. Fondness for music ran in the family. George played the flute, violin and piano. The theater he did not care for; but he frequently attended concerts, especially oratorios, in which music and piety were combined. His literal acceptance of the scriptures made him in the narrow sense of the

words a good man, honest and well-meaning, a loyal friend and a relentless enemy, the kind who never forgives nor forgets. His outlook may have been limited, but his morals were above reproach, which, in that golden age of libertines, was the more amazing. His asceticism extended to food and drink; partly from fear of obesity, he was exceedingly abstemious. The Hanoverians were either spendthrift or stingy, and George was not generous.

In his late 'teens he fell in love with Lady Elizabeth Spencer, and to judge by subsequent developments, never quite got over it. After her marriage to Lord Pembroke, he fell in love a second time with another beautiful English girl, Lady Sarah Lenox, but his mother and Lord Bute would not hear of his taking a wife of other than a royal family; and George did not feel himself strong enough to oppose them.

After George came to the throne in 1760 at the age of 22, Sarah, like Elizabeth, wedded another, and the young king was pushed in the direction of a dynastic alliance. He had the pick of the available princesses. It went without saying that his mother's preference for him would be a German. The ultimate choice fell upon Charlotte of Mecklenburg-Strelitz. She was anything but rich, anything but beautiful, but she was modest, virtuous and willing.

All England had been disgusted by the affairs of George II with a series of stupid, beefy German mistresses, and the idea of a respectable marriage promised a welcome relief. George III was well enough liked for his rectitude, openness and good nature, and considered rather handsome. The new queen was not too bad. A double coronation followed the wedding, and the royal couple were off to a good start. Charlotte tended to be serious and phlegmatic. A stranger to frivolity even in youth, she had no opportunity to develop a taste for the lighter side of life. George was a family man; and, for the next 20 years, Charlotte was nearly always pregnant. The king's domesticity was viewed with approval; and the queen gave birth to 15 living children.

The first hint of trouble came from the other side of the Atlantic; and the root of the trouble was money. England was emerging from the Seven Years' War. Pitt's foreign policy had paid off magnificently in territorial gains: Huge tracts passed from France to England—in Africa, India and America. But the returns from

these were not immediate, and the cost in men and money was high. Heavy losses in battle, heavy taxes at home, more than offset the glory for the common citizen and his wife. An effort was made to stem dissatisfaction by bringing pressure to bear upon the colonies. The worst losses might have been recouped in this way, but the Americans objected; and there were bitter controversies over the right of the mother country to tax the dependencies for her own benefit. The government was not loved. Pitt was a proud, violent man, brilliant but unpredictable. His influence was thrown on the American side. George opposed him, but in his relations to such a person the king's relative youth and inexperience left him at a disadvantage. When Pitt resigned the ministry, the king was exceedingly pleased; but there was widespread discontent among the people who remembered how many jewels Pitt had set in the crown of England. Lord Bute—no matter if the king admired and trusted him—was not the man to take Pitt's place at such a critical moment. The people resented him because he was a Scot—the Stuarts were still clearly and unfavorably remembered—and also because he was believed to be the lover of George's mother. To top this, he made an incompetent minister, and in 1763 was forced to resign.

The quarrel with the colonies worsened. There was terrific tension. George, stiffly maintaining his position, found his royal will opposed by irreverent mutineers. In 1765 he began to suffer from insomnia. He got a bad cough, ran a temperature and went into seclusion with a mysterious illness which lasted for about six months while everybody whispered and wondered. It became known only gradually that he had been seized with a mental disorder.

Half a dozen physicians were in charge of the case. George was treated according to the best wisdom of the day. With few exceptions, the essential plan for the treatment of mental illness has remained the same from the time of the ancients. In a modern hospital, however, George would probably have undergone electric shock, which has been used since 1939 with satisfactory results, especially in manic-depressives. But we have not been able, for all the advances of science, to improve radically on the basic prescription of rest and nourishment, sedative drugs, massage and baths,

fresh air and light occupation. Being a king, it is doubtful that George received the relief afforded by any form of the technique we call psychotherapy; but the unburdening of a tortured heart to a wise, informed and tolerant listener was then and is today one of the principal avenues of relief. Instead, he was heavily purged and blistered, procedures which we have abandoned.

Before uneasiness over his condition had become widespread, George began to show signs of improvement. Those behind the scenes breathed a sigh of relief and offered thanks. England had a king once more.

But the wheels of history had continued to grind, even while, for George, time was suspended. Affairs with America were heading toward a rupture. Pitt forced the repeal of the Stamp Act in 1766. Possibly if he had remained in Parliament the whole course of events might have been different; but in 1767 he, in his turn, had a mental breakdown which incapacitated him for two crucial years.

Lord North, who became prime minister in 1770, was an honest, agreeable and witty man. He was popular, but not strong, depending always on the direction of others. From George's point of view, this made him an ideal minister. North never crossed the royal will; and, although George's policies led swiftly to disaster, his mental health was all the better for the absence of conflict in his immediate circle. North remained in office until 1782, when it was apparent that the colonies were lost. He was followed by the younger Pitt in 1783.

George, in the meanwhile, kept his accounts and worshiped God. He was really a most deserving person. Unlike his own father and the earlier Georges, he was deeply interested in his country and in the welfare of the people. Devoid of any talent for government, he ploughed conscientiously through endless documents, and never neglected any form of public business.

In his private life he was a devoted husband, and, as long as the children were small, an affectionate father; but he was easily upset by opposition. It was doubtless in the hope of postponing as long as possible the day when his sons would begin to set themselves against him, that he kept them in the nursery until they were actually in their 'teens. The prince of Wales, in particular, was babied and dressed in ridiculously-juvenile fashion until he

rebelled. With George's ideals of royal eminence and god-like authority, he was a terrific disciplinarian, and kept the boys on a tight rein as long as he could. The moment that they could shake off their father's hand, which endeavored to hold them in the straight and narrow path, the three eldest went to the utmost extremes in the opposite direction. That George grieved over their immoralities and extravagances is certain. The queen was fond of the wild young princes and tried to act as peace-maker, but with little success. George's distress soon hardened into dislike, and he hated his heir as his fore-runners had hated their sons before him. "Prinny," as his friends called the prince of Wales, was an unattractive, undisciplined boy, given to tantrums. He took a vicious delight in torturing animals. As a man he fulfilled his early promise, and in spite of a certain charm, showed himself weak, vain, dishonest and cruel. George had little joy in him after he ceased to be a toddler. For love he looked always to his younger children. The favorites were his golden-haired little daughter Amelia, and his eighth offspring, the baby prince Octavius. When this pet died at the age of four in 1783, George sorrowed more than over the disastrous ending of the Revolutionary War. Great anxiety was felt over his reaction to the double blow, but at the time he seemed to have himself well in hand.

However, in the spring of 1788 George's behavior began to cause considerable alarm. His speech, always jerky, repetitious and staccato, became so rapid that it was often impossible to understand him. He was obsessed by regret for the lost colonies—a delayed reaction—and began to babble about the sweet dead babe, the best son he ever had. He complained of pain in his legs, of feeling weak, of not being able to sleep; and one day he came home from a long ride in a black mood, saying he wished he could die, for he was going mad. The king was tragically aware that he was slipping, having the usual insight of the manic-depressive.

The celebrated novelist, Fanny Burney, author of *Evelina*, was one of the queen's ladies in waiting. Any writer worthy of the name must have known what an opportunity this was for "copy," and she has left us one or two unforgettable glimpses of the sick man, his agitated wanderings, his incoherent muttering, his excitement. During the night, Miss Burney says, he was very restless,

kept coming into the queen's room to see if she were there, as children seek comfort from the nearness of their mothers, and repeated several times in a loud voice, as if to reassure himself, "I am not ill, only nervous." Nevertheless he grew, not better, but worse. He remained sleepless, haunted by a theme from Handel which he "could not get out of his head."

Toward Christmas a new physician was called on the case. "They talk of entrusting the king," the duchess of Devonshire wrote in her diary, "to a Dr. Willis, a clergyman, who is used to the care of madmen and treats them with kindness."

The Reverend Francis Willis, whose medical training consisted of a few lectures at Oxford, had a flair for treating the physical as well as the spiritual ailments of his flock. He was handsome, with a magnetic glance and an air of great authority. His success with mental cases was so great that he opened a private sanatorium. Questioned in Parliament, he claimed that he cured nine out of 10, but he was totally unable to back his assertion with figures, for he kept no records of any kind. His personality, nevertheless, inspired confidence—Miss Burney liked him immensely and called him a man in ten thousand. In any event, the king's state was desperate, and in desperate states we grasp at straws.

Willis had complete "domestic and moral" management, subject to the approval of the other court physicians headed by Dr. Warren. He moved into the royal suite with his two sons as assistants and three orderlies from his institution.

Two factions immediately formed. Willis, who said he thought the king would undoubtedly recover, was favored by the queen and the younger Pitt, to whose interest it was to have him restored. Warren, who took the pessimistic view, was backed by the prince of Wales, who by this time had lost any semblance of affection for his father, and hoped for the worst.

Certainly the king manifested some very disturbing symptoms. He was now 50 years old, a dangerous age. Besides dwelling on the loss of little Octavius, he began to murmur about his frustrated passion for Lady Elizabeth Pembroke. Her presence among the queen's attendants rekindled the smouldering flame. He began to have delusions about her: He thought that he had divorced Charlotte and had married his Eliza; and on several occasions he forced

himself upon Elizabeth in the midst of his paroxysms and wildly urged her to take her rightful place beside him on the throne.

Although the queen knew that he was not responsible for his mad words, she must have been affronted by such scenes, but she rested on George's 27 years of conjugal fidelity. Until then no breath of scandal had ever touched their marriage. She stood by him and continued to believe that he would be well again, although his mania rose to such a pitch that he once talked for 19 hours without stopping and, when hoarse and exhausted, he fell asleep, it was only for a brief two hours, after which he began his senseless raving once again. At the height of this fury it took four strong men to hold him.

It was during this terrible period that Willis obtained permission from the chancellor to put the king in a strait jacket. At worst George was neither assaultive nor suicidal, nor did he try to destroy his clothing or the furniture. From all that can be learned, Willis used the restraint as a form of discipline, "to subdue turbulence and increase self-control."

There was a story current to the effect that the king was one day pacing his room accompanied by a gentleman in waiting; and, as they passed a chair on which the strait jacket had been thrown (perhaps as a reminder), the courtier delicately averted his gaze. "You need not be afraid to look at it," said George, "Perhaps it is the best friend I ever had in my life." It cannot be supposed, however, that he ever liked to think of force applied to his person, or of other physical measures that were tried. He was dosed with "bark and saline medicines," emetics and cathartics. He was examined by all his half-dozen doctors every day, each of them jealously watching the others, as well as the patient. The truth concerning his illness had filtered through to the people, and there was talk of establishing a regency, but quiet intervals were becoming longer and more frequent. As George improved he received sedative baths—these at least he enjoyed—and occupational therapy of a sort, for he was not only permitted to read and play games, but encouraged to practise on the flute and to tinker with clocks, an employment of which he had made a hobby.

It could no longer be denied that the clouds were passing, and on February 25, 1789 the medical council agreed that George was

"free from complaint." The regency proceedings were halted. By the end of March the king was again making public appearances. One of the first was to inspect a new almshouse. With his usual conscientious devotion to detail he went through all of it, and spent extra time in the wing designed for "insane paupers," pleased with the arrangements for their safety and comfort. There was a thanksgiving service at St. Paul's at which he behaved with dignity, although it was apparent that he was deeply moved. At the end he burst into tears.

With the queen, he went to Weymouth for some months of the country life he loved, and all the way his loyal subjects crowded the roadside, cheering. He had never been so popular in his life. The contrast between George's sober virtues and the scandalous cavortings of his sons would have been enough to tip the scales in his favor, but over and above this, his sickness had aroused pity, and there was general rejoicing at his recovery. He resumed his customary frugal rounds and open-air excursions, and tried to carry out the parting injunction of Dr. Willis to get at least six hours of sleep every night.

The expectations of the prince of Wales and his disreputable hangers-on were disappointed. For the next 12 years the king enjoyed good health. He lived simply. His awkward, bumbling gait, his rapid speech, interlarded with his favorite ejaculations, "Hey, hey, hey," or "What, what what," endeared him, if anything, to the populace. He was not notable for charity, but he set up a mill to grind corn at special rates for the poor. When he encountered common men and women in his walks and rides, he would stop to talk to them like a common man. His unpretentious dress and manner made it evident that in any case, wealthy though he was, he did not squander money on himself. The queen was always with him. Lady Elizabeth Pembroke remained at court and the king's relations with her were those of ordinary friendship.

But there were disturbing incidents. The French Revolution proved more upsetting than the revolt of the colonies, especially as it involved regicide and the execution of so many nobles. Friction with the prince of Wales was sharp and incessant. The prince married, in 1795, and callously mistreated his wife, Princess Caroline of Brunswick, of whom George was very fond. Then there

was the matter of Roman Catholic emancipation. George was determined not to yield on the point of giving Roman Catholics full civil rights, and the die-hards supported him. After a raging controversy Pitt resigned over this issue in 1801. The king's familiar symptoms reappeared; again he began to lie sleepless, to appear flushed and agitated. He knew that he was in a dangerous condition, and begged Charlotte not to call Willis, for whom he had formed a definite dislike. His wishes were respected, especially as summoning Willis would have broadcast the bad news to the nation. Many of the court, however, felt that Willis would have been more adroit in handling the intricate problems arising out of the royal illness than the physicians who were placed in charge. Willis was accustomed to the in's and out's of high society. He was not confused by questions of who might and might not be received, and similar matters requiring more than ordinary experience and tact.

This time, luckily, the episode was not very long or severe; but while it lasted, the king was in an uncommonly harsh and overbearing mood, and treated his family, pages and attendants very roughly. In an attempt to clear his mind the doctors blistered his scalp, and someone gave wide circulation to an unfriendly rhyme:

> If blisters to his head applied
> Some little sense bestow,
> What pity 'tis they were not tried
> Some twenty years ago.

In spite of the treatment, recovery eventually set in. George gradually improved, and began to be seen in public again before it became common property that he was sick. Once again, tentatively, he felt his way back to his usual routine, upheld by the affection of the queen and the obvious sympathy of the people.

To George, with his deep vein of piety, his repeated afflictions must have seemed like those of Job. He was once heard to say that he hoped he was resigned to God's will, but that he must be a great sinner or he would not be so sorely chastened. (We cannot know what comfort he obtained, but it was probably much, from the feeling that his attacks were trials of his faith and obedience.)

Meanwhile, across the Channel, Napoleon was swiftly consoli-

dating an empire. His imperialistic drive made war with England inevitable. George took great interest in the preparations. The prince of Wales wanted to participate, and demanded an important rank in the army. This the new prime minister, Lord Addington, promised him, but George considered his son unfit for high command, and Addington was dismissed. It was no sinecure to be one of George's ministers and to live in constant fear of doing something that would set off another of his spells.

He suffered from fluctuating moods of cheerful courage and bleak depression. His favorite daughter, Amelia, had fallen in love with her equerry. The king forbade marriage but she could not master her passion, and said that if he continued to refuse his consent she would marry without it. But a new element entered the situation. Amelia had long been delicate, and it became apparent to all that she was going into a decline. Her father tried not to see that she was in the terminal stages of tuberculosis. Her death in 1804 precipitated his fourth attack of psychosis. The queen steeled herself for it when he fell asleep in church, for to George the service was always a profound experience, and the least inattentiveness was unheard of. He was suffering from a severe chill and a feverish cold; mounting excitement culminated in violence. His ravings again had a strong sexual coloration; and he rejected his patient wife. Even after his recovery they did not resume their former harmonious life together, but remained estranged. When she died, a few years later, he did not even know it, as he was sunk in his last depression.

Dr. Willis was summoned. This time he said the king's condition was more like "delirium" than "insanity:" He was almost continuously manic but had few delusions, and there were brief remissions when he was well enough to see his ministers and transact state business.

By the time he had recovered, the war with France was in full blast. Nelson won his glorious victories and died at the battle of Trafalgar in 1805. The year after, Pitt went to an early grave at 46. George had a new trouble. His vision was impaired by cataracts and he could no longer make out the printed page. Like Milton he had his daughters read to him. The savor had gone

out of every experience; he had nothing to live for any more, but he was still physically robust. At three score and ten the habit of living was strong in him.

By 1810, when it became apparent that George's mind was failing again, his vision had gone entirely. The cataracts might have been removed, but this illness was before the discovery of anesthesia, and the risk of operation was so great that nobody would attempt it. The king had lucid intervals when he solaced himself with music. In 1811 he made up the program for a special concert, and it was found that he had chosen all the finest passages in Handel, particularly those dealing with madness, blindness or family tragedy. (How often he must have compared himself with Samson or Jephtha!) The closing number was, of course, *God Save the King!*

One day the queen found him singing a hymn and accompanying himself on the piano. At the end he knelt down and prayed aloud for the nation, for his household and for himself, and as he begged for the restoration of his mental powers, he began to sob. For a while he harbored the pathetic delusion that he was dead. "I must have a suit of black," he said, "in memory of George III. I know there is general mourning for him."

From time to time his madness cleared sufficiently for him to renew his interest in government, but, as the months wore on, his age and the accelerating tempo of the attacks pointed to the necessity for a regency. The prince of Wales to all intents and purposes succeeded to the throne while his father still lived.

George III survived 10 years longer—except for Victoria's his was the longest reign in English history—blind, and for a long period deaf as well. But his hearing was spontaneously restored, which gave him back at least the enjoyment of music. He had several pianos and harpsichords in his suite, and as he walked about he would stop occasionally to play a few bars of Handel. For the most part, now, he was quiet and cheerful. Consciousness of his environment left him, and with it the barb of old unhappiness. He lived entirely in the past. His beard grew long; it lay on his breast in a drift of white. He looked like a blind patriarch, a prophet, dignified, wise, sad.

At the end of 1819 his appetite began to fail. In January of the new year he could neither eat nor keep warm. On the twenty-seventh he took to his bed, and on the twenty-ninth he died. He was then 81, a poor old man, sick, mad, defeated, but still trusting in God.

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SEDITION: A CASE REPORT*

BY DAVID J. FLICKER, M. D.†

Certain opposing convictions show marked similarities in their definitions, manifestations and motivating causes, and in the psychic soil in which they best take root and flourish. The difference between a patriot and an enemy spy, a zealot and a heretic, a martyr and a torturing inquisitor, is psychologically often far less than it appears. When an individual is so devoted to a cause that he is willing to lay down his life for the furtherance of it, he may be known in his native land as a patriot and a hero. If he is a member of a hostile force and battles with equal vigor, he becomes a fanatic. If the cause be religious, he is a martyr—when the religion is one with which sympathy is held. He is a heretic when his religion is not sympathetically regarded. It must be noted generally that these are the herd viewpoints. We usually do not vilify or hate the individual who opposes us; we condemn and hate, rather, his herd or group. But the judgment of the herd is always *most* severe against any of its own individual members who desert or oppose the herd objectives, especially at times when outside factors menace the existence of the group. The fundamental law of "survival of the fittest" is the basis for this reaction, especially since we are no longer dealing with the "fittest" individuals but rather with the "fittest" tribe.

Since the organization of the first clan, group preservation has been considered more important than the preservation of any of the individuals who might compose the group. On this principle, society and social organization are based.

Dangers from within are more feared and hated and produce more violent reaction than dangers from without. The enemy who speaks against the herd may be incarcerated for the duration of a conflict or expelled from the group area. The group member who speaks against his group is regarded with revulsion and fierce hatred and no penalty is considered too severe for him.

*This article was written while the author was on active duty with the U. S. Army Medical Corps.

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In democratic countries when the nation is not at war, minority groups may freely express viewpoints contrary to the majority opinion. Orators advocating changes in the government have long been tolerated in Hyde Park and Columbus Circle.

Society organizes subgroups of its members to fight for its protection and preservation when necessary—that is, the armed forces. Within these groups a minority is not permitted to express its political views; in particular is this expression forbidden when the function of defense is being actively performed.

Society frowns upon that member who expresses views contrary to those held by the majority. However, this disapproval is mild when contrasted with the reaction created when a member of the subgroup assigned to the protection of the herd directs his energies contrary to that which the herd has decided is in its own best interest and for its own preservation.

What psychic motives cause a member of any group to turn on his brothers? And when one does so, is he in the medical and legal sense of the word "insane" if no other evidences of "insanity" can be elicited?

Take the case of a soldier who, after 14 months of service, suddenly became recalcitrant, refused to obey orders, had to be tube-fed, felt that he should be punished for some unforgivable sin (the exact nature of which he did not know), and stated: "I have got a right to live, I don't want to die, I won't fight, why should I die, I won't fight because I might get killed." All the while he assumed catatonic postures. This man presented little problem, either from the medical or the legal standpoint. Charges were not placed against him. He was, instead, placed in an institution for the mentally ill.

This paper presents a case in which the solution was not so simple.

To explain why all general court-martial cases first reach the psychiatrist before going to trial, it is necessary to comprehend the liberal and extremely advanced position of military forensic psychiatry. The *Manual for Courts-Martial,* insofar as the writer could determine, makes no practical differentiations between medical and legal "insanity"—a far-advanced and laudable viewpoint that the civil law could well emulate.

Following are a few excerpts which give the military viewpoint:

It is elementary that an insane person is guiltless of criminal intent and is to be held as innocent of the offenses.[1]

A reasonable doubt was raised as to the mental capacity of the accused to commit the wrongful act charged, and it was incumbent on the prosecution to prove that the accused was capable of entertaining the necessary intent.[2]

No charge will ordinarily be referred for trial if he (the commanding officer) is satisfied that the accused is insane or was insane at the time of the offense charged.[3]

An appointing authority may in his discretion suspend action on the charges pending consideration of the report of one or more medical officers, or the report of a board convened under Army Regulation 600-500 in a case where that regulation applies and it is practicable to convene such a board. The medical officers or board will be fully informed of the reasons for doubting the sanity of the accused and, in addition to other requirements, should ordinarily be required to include in the report a statement in as nontechnical language as practicable of the mental condition of the accused both at the time of the offense and at the time of the examination.[3]

The court will inquire into the existing mental condition of the accused whenever at any time while the case is before the court it appears to the court for any reason that such inquiry ought to be made in the interest of justice. Reasons for such action may include anything that would cause a reasonable man to question the accused's mental capacity either to understand the nature of the proceedings or intelligently to conduct or to co-operate in his defense. For instance, the actions and demeanor of the accused as observed by the court or the bare assertion from a reliable source that the accused is believed to be insane may be a sufficient reason.[3]

Case Report

Hugh C. was admitted to the neuropsychiatric section of a station hospital for mental and physical study on March 13, 1942. He was a 36-year-old white man, of Irish extraction, of Roman Catholic faith, reported as having been in military service for one week.

The general physical examination revealed no pathological find-

ings. The laboratory reports, including blood count, Wassermann tests, urinalysis, spinal fluid studies, blood chemistry, and x-rays of the chest, skull, and spine, were all normal.

Chief complaint: "I have got a pain in my back and numbness and soreness in my legs. I don't want to fight on the same side as the British or Russians."

PSYCHIATRIC WORKUP

History: The patient said that his father and mother were both dead, that he knew nothing of them. On one occasion, he admitted that he had heard something about his father from a clergyman, but he refused to divulge this information.

He was born in Belfast, Ireland, an only child so far as is known. He knew nothing of his birth and early childhood. In his earliest memories, he was in a convent; his life there, he stated, was neither happy nor unhappy and he looked back upon it with indifference as having been "the only way" for him to be taken care of. At the age of nine he left the convent and went to work on a nearby farm, where he remained until he was 25, at which time he came to America.

While in the convent and on the farm, he attended a national school, but rather irregularly. He feels that he got little out of school, and could not recall having learned very much. Although he said that he had little time for study or recreation, he mentioned having been in politics and having been a member of the Sinn Feiners; but he was reticent about his Irish political connections.

At the age of 25, after waiting two years to get into the country under the Irish quota, he succeeded in coming to the United States through the influence of some friends of his employers. In rapid succession, he worked as a laborer, as a houseman in a hotel, as a hospital orderly, and then, finally, as a factory hand. In 1938 he returned to Ireland for about three months and, while there, talked to a number of politicians and newspaper reporters. He resented very much the questioning by British officials and restrictions on the issuing of his passport, since they limited his stay in Ireland and forbade him to obtain a job there. He "bragged" that if he had remained a short time longer he would have seen De Valera.

In 1939 Hugh made a trip to Detroit to see Father Coughlin. He said he was an enthusiastic believer in Father Coughlin and followed him faithfully. He proudly stated that he had several letters in his possession from Coughlin. He felt that the "Father" was discriminated against and complained that he was not allowed to speak freely over the radio and that several halls had been denied to him when they had been open for the use of Communists, such as Earl Browder. Hugh has been a devout Roman Catholic all his life, reads the Bible, attends confession and mass regularly. No religious aberrations were noted.

He has never been interested in any one girl and in general, is not particularly fond of girls. He has had several female friends but on a platonic basis only. On one occasion about nine months before his admission to the hospital, he was induced by a friend to have intercourse with a prostitute. He contracted gonorrhea. He had had only a few sexual experiences.

Since Hugh had been in America he had read, studied, attended lectures, and listened to the radio as much as possible; and, by these means, he considered himself educated. He had fixed, unyielding views on most subjects.

In New York he was a member of the America First organization and the Father Coughlin National Unit, neither of which is now in existence. He stated he still believed in their principles.

* * *

When the patient was notified to appear for military service he wrote the following letter to his draft board:

Dear Sir:

I have received your letter notifying me to report for induction into the armed service of the United States, on March 4th. Now that I have complied with most of the Selective Service Act requirements, I wish to inform those whom it may most concern that I desire not to be sent over to Europe, Asia, or Africa, to fight in behalf of British imperialism or Russian paganism.

When I became a citizen of this country in 1936, I was asked to denounce my former ruler who was then the British Government. I need not tell you how proud and overjoyed I was for having the privilege of renouncing this Government who is the world's great-

est plunderer, the world's exploiter and like the Russian Government the world's greatest murderer.

When I took the oath of allegiance to uphold (not the New Deal politicians) but the Constitution of the United States, I was asked if I would take up arms in defense of the United States, I answered Yes, but I did not then, and do not now, consider fighting on a foreign land as defending the United States. The result of Pearl Harbor is proof for this statement.

If the New Deal politicians had been half as much interested in protecting the Philippines as they were interested in protecting the 132,000 acres of rubber plantations in the Malayan Peninsula belonging to such bankers as the Kuhn Loeb, J. P. Morgan, and W. W. Davis, there would not have been any lives lost or any disaster in the Philippines. It is because of these international bankers and their African and Asiatic wealth, that our country is at war today.

When the New Deal politicians tell us, that we are fighting in this war in order that the people of the world might be free, I wish to tell those politicians that they are just plain down right prevaricators. It is only a few years ago that a three and half years war ended in that great Catholic country Spain. And in this war thousands of Bishops, Priests and Nuns were slaughtered and their Churches burned to the ground by those Russian Bolshevikis who are the world's greatest murderers and not as much as a murmur of protest against such brutality came from any New Deal politician and again when the Priests were shot to death on the streets of Mexico, and when President Roosevelt was asked to intercede in behalf of these persecuted catholics whose Churches were closed and still closed, He replied by stating that he did not see his way to interfere in the domestic affairs of another country. But when an extra tax was imposed on the Jews in Germany because of a crime committed by one of their race against a German Minister in Paris, President Roosevelt caused world-wide excitement by calling home Ambassador Wilson from Berlin. From that day on the New Deal politicians were forever more attacking the German people and their leader, Adolf Hitler, as a result of these attacks Germany had no other alternative but to declare war against the United States.

Although Germany and Italy is at war against the United States, I do not consider these countries as enemies of the United States, but rather I consider the New Deal Politicians as enemies of Germany and Italy. The reason why these New Deal politicians are enemies of Germany is not because Germany has taken over country, after country, but because Adolf Hitler had the courage to do what President Roosevelt promised to do, and failed to do, namely to "drive from public office the unscrupulous money changers."

The past acts of the New Deal politicians is enough to convince me that this war is not a just war. It is a war amongst the have, and have-not nations. It is a war to protect the interest of the international bankers whose real title should be international gangsters. It is a war to protect international Freemasonry the secret enemy of the Catholic Church.

It might be well to remind those New Deal politicians of that ancient proverb "Those who live by the sword shall perish by it." France was the first to officially declare war on Germany. She set out to live and conquer by the sword and she too perished. And if the American suckers had not given war aid to England, she too, would have long since perished.

* * *

A few excerpts are here inserted that were taken verbatim at various psychiatric interviews.

(Have you ever been in difficulty with the police?) Only the once I was telling you about. This speaker in Columbus Circle, I merely asked him a few questions, he was speaking wrong about the lend-lease bill and I asked him a few questions concerning democracies. I brought up about how all the nations . . . some lady asked him what this lend-lease bill would do for Russia and of course he went on to explain that this lend-lease bill was to aid all the democracies against Hitler, and then I asked him did he call Russia a democracy? He said no he wouldn't. I said to him, "Well, I am glad that you gave a fair statement. Do you really know what the definition of democracy is?" He explained what it was in his way. I pointed out to the audience that democracy was, according to Winston's dictionary, a government of the people, also of the community so governed, as opposed to aristocracy,

What was the kinged heads of Europe? Or the aristocracy class. What was the king, the House of Lords? Only of the aristocracy class. I called it hypocrisy, calling not only America a democracy, when democracy doesn't appear in the Constitution of the United States, but calling England a democracy when democracy was opposed to the very thing existing in England, namely, aristocracy. But he got sort of ferocious, rambunctious, had this cop come and take me out of the crowd. I says, "Thanks, Officer, for taking me out. After all, I should feel honored because it's a waste of time talking to him." He says, "I know what your viewpoint is and I don't want to get you in trouble." I said I was merely trying to show him where he was wrong in regard to Russia. He told me if I wanted to have any meeting all I had to do was get an American flag. . . . I was just as good as they were. So that was all right. I tried to talk to this fellow very nicely and I tried to go into detail, trying to answer the questions. His purpose was to hold the audience . . . some of the old women were heckling me . . . and he says, "Pay no attention to this fellow—he is a Coughlinite." He says, "I have stayed until 4 o'clock in the morning arguing with this fellow." "Now, now," I said, "after all . . ." and of course previous to that I did boost him about how he was a very good speaker and of course all good speakers always come to the point about answering a question, but of course I told him his purpose was to hold the audience. After me pressing him, he said, "I wonder an intelligent fellow like you would argue with a fellow like me." "One is always entitled to instruct the ignorant," I said. The audience laughed and he laughed. Then I approached him on another subject, and he called the officer.

(Have you made speeches at Columbus Circle?) Well, I tell you, I used to make speeches. I would ask questions and the result would be that I would be holding the audience instead of the fellow that would be on the soap box.

(Did you get his soap box?) Yes, I did. Back in 1936 I would go down to Broadway and 92nd Street. There was a speaker there at the time of the presidential election. I was listening to them a while. They were all for the New Deal and praising Roosevelt. Somebody asked him to tell him how he would save banks and then I told them how Roosevelt saved the banks. First of all, you recall

the bank crash which occurred in 1933. President Roosevelt called the bank holiday—that was to close the banks and to stabilize them. So I pointed out that what he did was to call this bank holiday, first of all he borrowed from the banker's two billion dollars of the depositors' money. You recall how you went to your banks. I pointed out in 1933 in his first inaugural address, "Plenty is at our doorstep. By the generous use of it . . . languishing in the very site of the supply. Primarily this is the cause, that the rulers of exchange of many kinds of goods have failed through their own stupidness, through their own incompetence, have admitted their failure and abdicated. Practices of the unscrupulous money changers who stand indicted before the courts of public opinion, rejected by the hearts and minds of men . . . by their efforts have been cast into a pattern of an outworn tradition, faced by the failure of credit, they proposed only lending more money." Then I said these were the words of President Franklin D. Roosevelt on March 4, 1933. I stated, "Strong words were these. No greater words could be uttered by any President than were these words of President Franklin D. Roosevelt." Then I asked them, "Now," I said, "how did he serve the banks? He loaned these bankers two billion dollars of the taxpayers' money in order that they might stabilize the banks and face the depositors with credit." Then I asked, "Where is the logic in loaning two billion dollars to these men and turning around in a few short months and borrowing from them approximately 18 billion dollars to finance the various alphabetical letter projects, such as WPA, etc.? Where did the bankers get this 18 billion dollars from? I will tell you how they got this 18 billion dollars. They created it by a mere stroke of the pen and as a result you and the general public were led to believe that they were in debt to the tune of 18 billion dollars." And I pointed out, "Now you all revere the Constitution of the United States, and in this Constitution it states, in Article 1, Section 8 and Paragraph 5, that Congress has the sole right to issue, coin, and regulate money. Who issues this money? Only those so-called Federal Reserve bankers, who are no more Federal than a Chinaman's laundry." Then I pointed out also, I says, "Most of you people, you often wonder why you are really starving, particularly you married people. You go down in any shopping district and you will see the

beautiful displays in the window gazing out at you and you gazing in at them, and naturally these displays . . . most of you say to yourself, 'Why, I wish I had such and such a thing' and you let a sigh and walk away and say to yourself, 'Well, there is no good in looking at it, I just can't have it.' Why can you not have it?" I asked, "Simply because you haven't got that thing called money, which is only a token to your real wealth. What is wealth?" I asked. "Wealth is not money, wealth is the necessities of life, the comforts of the home and things in general." Then that is what I tried to point out to them. Then I stated that, I said, "The trouble is with you Americans that . . . I pointed to the fact that if you want to put that before, I am very proud of the fact that I am an American citizen, but I regret to say that 60 per cent of you Americans are gross ignorant—ignorant of the affairs of your government. Most of you will fall for what you read in the capitalist press, such as Dorothy Dix, Orphan Annie and Dick Tracy, which is of no value to you and will be a long time filling your stomach if you are in dire need. The thing for you people to do is to get interested in your government, get interested in the politicians, and decide who is really the man who should be elected."

(Do you think the President of the United States is a dictator?) In a sense, indirectly.

(Do you consider Japan right in its attack on Pearl Harbor?) Yes, she was justified under the conditions.

(Do you feel that the United States was justified in declaring war in retaliation for that attack?) Well, I say no. They should have examined the whole thing over and over and found that they were at fault, as I stated, that we played the role of a bully; we thought with our great resources we would make Japan surrender and we thought it was none of our business if Japan went into China or further into Thailand. I felt our real concern was not the Philippines, and I so many times stated, we always referred to the Philippines as "those damn old spicks"—such as that. Love for them didn't seem to be so great, and I felt it is because they were Catholics.

(Do you think the United States as a matter of principle is opposed to Catholic countries?) Yes, they have shown that.

(Do you think that Germany was justified in declaring war on the United States, following the attack by Japan?) Japan only did what we were doing in regard to England—rather Germany—by helping an ally and keeping to an agreement, and I felt that Germany was just as much justified in aiding Japan as we were in aiding England.

(Do you consider that Germany, Italy, and Japan are enemies of the United States?) No. Since 1934, Germany . . . it has been many times stated that Germany was one of our best consumers in regard to purchasing cotton, and I recall reading some time ago where the German government was purchasing 104 million dollars worth of cotton from the United States—much more than the British government was doing.

(If you were sent to the front firing lines against German, Italian, and Japanese troops, would you fire at them?) It wouldn't be with my desire to do so; it would just be a case I would have to. (Why?) Naturally, I would feel I would be asked to do it—it wouldn't be with spirit. And I feel if I possibly could get out of it, I wouldn't do it because I don't consider them enemies. I feel the enemies are the leaders of nations and not my fellow-men.

(If you were stationed at an anti-aircraft gun in the United States and a Japanese, Italian, or German warplane appeared, how would you feel about firing on them?) Well, the feeling would be as I have said before. If I didn't fire there is a possibility that somebody behind me would fire on me. It wouldn't be firing in spirit.

Comment

How far can a thought, idea, or concept vary from that commonly accepted and still remain within the realm of the sound mind? A false belief or thought differs from a delusion in that when adequate contrary evidence is presented the holder will relinquish the former; but, from the latter, he cannot be dissuaded by logic.

Adequate grounds for decision or opinion in any social milieu are data which the majority accept as such. Thus a delusional belief that would be considered markedly pathologic in a college grad-

uate might indicate little abnormality in the Australian blackfellow. The question of culture is all-important in assessing the import of a delusion. But in certain aspects of life, as in religion or politics, a much wider range and tenacity of thought and belief are acceptable. The Mormon who believes in polygamy is not considered "insane," but if he attempts to practise polygamy, he is prosecuted. If a citizen believes in anarchy he is not considered "insane," but if he attempts to put it into practice he may be prosecuted.

Hugh C.'s syndrome could be interpreted as "monomania" if one cared to accept the existence of such an entity, but considerable mental gymnastics would be required to fit it comfortably into any psychopathologic nosologic entity. The patient displayed, at most, an impairment of judgment and reason, but this was confined to his political views. His affect as to patriotism, the nation's leaders, the war, and the nation's enemies, was abnormal when compared with that of our citizenry at large, but was in harmony with his expressed views.

". . . Strange ideas may seize upon otherwise sound individuals. Groups and societies, even whole peoples, may have seizures of a similar kind; these are mental epidemics. In such a case only malevolent critics speak of a psychosis, while others speak of an 'ism.' The ordinary lunatic is generally a harmless, isolated case; since everyone sees that something is wrong with him he is quickly taken care of. But the unconscious infections of groups of so-called normal people are more subtle and far more dangerous . . ."[4]

The refutation, from the legal standpoint, of the patient's arguments is so concisely, succinctly, and excellently phrased by the following quotation from Mr. Justice Harlan, in speaking for the Supreme Court, that the writer feels it should be given in full:

"He may be compelled by force, if need be, against his will, and without regard to his personal wishes or his pecuniary interests, or even his religious or political convictions to take his place in the ranks of the army of his country, and risk the chance of being shot down in its defense."

Possibly all demagogues and their followers should be considered "insane." Certainly they often hold ideas which make it dangerous for them to be at large, but to carry psychiatry to such extremes would constitute a dangerous academicism, a *reductio ad absurdum.*

The soldier was found sane and remanded for trial.

82 Clinton Ave.
Newark 5, N. J.

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THE BROOKLYN STATE HOSPITAL PSYCHIATRIC FORUM

BY IDA BRAIMAN AND PATRICIA FARRELL

In the fall of 1946, some of the younger physicians of Brooklyn State Hospital, in informal discussions, reached the realization that there was a great need in their community for a more extensive knowledge and better understanding of mental hygiene principles and their application. There was little question that there was great community interest; but there was no central organization to disseminate information to the general public. Because an educational project of this scope would entail much planning and community organization, the social service department, the nursing division and the occupational therapy department were invited to share in making plans. Representatives from all groups formed a steering committee.

Dr. Julius Rubin, a newly-returned veteran, spear-headed the organization of an interested committee and gave much of his time and effort to its development. He envisioned the place and growth of this service to the community and was able to transmit his faith and confidence in the forum to the committee. He saw to it that suitable persons were entrusted with the proper tasks and coordinated the work of all the subcommittees.

Another very active and capable founder of this program was Dr. Harry Joseph, a veteran recently returned from service with the navy. His optimistic personality often stimulated the group when pessimism and difficulty threatened its spirit. He acted as chairman of the important program committee of which the function was to select and engage speakers. Also serving on the program committee was Dr. Joseph J. Villara who was elected vice-chairman for the current season and who now heads the program committee.

The organization of the forum as it was tentatively set up for presentation to a general meeting of all interested hospital employees was as follows: (1) Membership in the forum was open to all employees of the hospital. Dues were set at $1.00 a year. (2) The executive committee was to be composed of several representatives to be designated by the members of each department in

the hospital. (3) There was to be a series of eight monthly lectures designed to stimulate interest in and promote a broader knowledge of mental hygiene and its related fields. These lectures would be held on the first Thursday of every month in the auditorium of Brooklyn State Hospital.

This outline was presented to Dr. Clarence H. Bellinger, director of the hospital, who gave enthusiastic support to the project and offered suggestions and helpful criticisms. He promised to provide refreshments for the audience following each forum. Dr. Nathan Beckenstein, assistant director and co-ordinator of educational programs for the hospital, was assigned by Dr. Bellinger to act in an advisory capacity and was consulted frequently whenever we felt that administration help or advice was needed. Dr. Bellinger gave the use of the hospital assembly hall, an auditorium seating 850, with a stage, motion picture projector, and a slide projector.

By a publicity campaign, the hospital employees were canvassed for membership in the forum; and a general meeting was called. At the meeting, the foregoing program was presented; members of the permanent executive committee were selected and officers for the year were elected: Dr. Rubin, chairman; Dr. Joseph, vice-chairman; Miss Ida Braiman of the social service department, secretary; and Alton Pickert of the nursing staff, treasurer. Representation on the executive committee included attendants, nurses, occupational therapists, social workers and doctors. The program committee, a subgroup of the executive committee, drew up a panel of speakers, outstanding in their respective fields, to be invited to address the forums.

The social service department made up a mailing list of all the recognized social agencies, medical schools, schools of nursing, hospitals and colleges in the New York area. All qualified psychiatrists were also included. Announcements of each forum were sent out with a covering letter requesting that they be posted on bulletin boards. After the first forum, requests were received from many persons in the audience to be placed on the mailing list and the practice of mailing individual postcard announcements was inaugurated. All posters, postcards and stationery were printed on the hospital press under the supervision of

Miss Susan C. Wilson, senior occupational therapist. Henri A. Girouard, R. N., calling to his assistance various members of the nursing and attendant staff, as well as patients, sent out monthly, approximately 1,400 pieces of literature to all the people and agencies noted.

To publicize the forums and to gain more popular support, leading New York and Brooklyn newspapers were notified each month of the scheduled speaker and the topic, as were the county medical society journals, *The Journal of the American Medical Association, The Interne,* and *Better Times,* an organ of the New York City Department of Welfare. Most of these publications co-operated by printing announcements of the forums each month. *The Brooklyn Daily Eagle* on several occasions assigned a reporter to cover the lectures and gave them front page space. Miss Patricia Farrell of the social service department was put in charge of publicity for the forum.

During the 1946-47 season, eight forums were held, one on the first Thursday of each month in the assembly hall. The panel of speakers included some of the most outstanding persons in the fields of psychiatry and neurology. The opening speaker in October 1946 was Dr. Nolan D. C. Lewis, director of the New York State Psychiatric Institute, who discussed "The Graphic Art Productions of the Mentally Disordered and Their Therapeutic Uses." By means of slides and case citations, Dr. Lewis illustrated the projection of conflictual and fantasy material into the art productions and discussed how these could be utilized as aids in determining psychodynamics, diagnoses and prognoses in individual cases.

In November Dr. A. A. Brill spoke on "Normal and Abnormal Mental Processes." He presented a history of the development of psychoanalysis and, by means of case material, illustrated such mechanisms as projection, repression and regression.

The following month Dr. Frederic Wertham selected as his topic, "Social Psychiatry." He touched upon the effects of environmental conditions on the individual and covered the problem of preventing abnormalities in children subjected to poor environments. He urged psychiatrists to be more active in working toward the

alleviation of social ills through social action rather than to be treating the individual in a vacuum.

Dr. Foster Kennedy spoke in January 1947 on "Neurology Is Psychosomatic Medicine." He held that there is a life force common to all living creatures and that the variations in this flow of energy produce mood swings in personality, the extremes of which are readily identified in the psychoses. He advanced the theory that eventually the classification of psychoses may stem from the manic-depressive.

The fifth speaker in the series was Albert Deutsch, who received honorable mention in the Lasker Award for his writings in the field of mental hygiene. He looked "Toward a National Mental Health Program," deploring the lack and poor quality of most of the existing facilities for the care of the mentally ill. He stressed the need for larger public appropriations for the erection of institutions; for training of personnel, and for adequate salaries in order to attract and retain qualified personnel. He urged that the professional workers in mental institutions share their knowledge of the facts with the public so that remedial legislation might be introduced.

In March Dr. Perry Lichtenstein, alienist from the district attorney's office (Kings County), discussed the problems of the psychopath whose behavior brings him into conflict with the law. He cited many cases from his own experience as an alienist and pointed out the lack of facilities for the retraining of persons diagnosed psychopathic personality.

Dr. Lauretta C. Bender, research psychiatrist at Bellevue Hospital and authority on childhood schizophrenia, spoke the following month on "Schizophrenia in Children." She described in detail many of the symptoms found in childhood schizophrenia and emphasized the constitutional factors. She illustrated her lecture with case references and slides.

The final speaker in the series was Dr. Bernard S. Robbins, professor of psychiatry at New York Medical College, who discussed the "Origin of the Neuroses." He traced the development of psychiatric thinking about the origin of the neuroses from the Freudian concepts through the modifications of more recent schools of psychiatry. While recognizing the importance of delving into the

genetic and developmental history of the individual, he also stressed the importance of focusing on current disturbances in inter-personal relationships.

The enthusiasm of the community demonstrated itself in the capacity audiences of about 900 who attended most of the forums. The only months during which the auditorium was not filled were those of the initial forum and the one in January which fell at the tired end of the holiday season when the nursing of hangovers takes precedence over the thirst for knowledge. The popularity of the forums manifested itself, too, in the continuous stream of telephoned and written requests for information about the forums and for placement on the mailing list which, by the end of the season, numbered 1,000 names.

The executive committee was interested in the composition of the audience and distributed two questionnaires during the season which were later analyzed as to name, address, occupation, organization affiliation, and manner in which persons had heard of the forums. Comments and suggestions were also invited. The analysis of the questionnaires revealed the following information:

I.	Occupation:	
	A. Professional	451
	1. Physician	33
	2. Psychologist	21
	3. Social worker	98
	4. Nurse	156
	5. Teacher	33
	6. Other (Clergyman, lawyer, pharmacist, personnel technician, engineer, chemist, occupational therapist)	76
	B. Students (Medicine, psychology, social work)	210
	C. Industrial and commercial workers	103
	D. Housewives	42
II.	Geographic distribution:	
	A. Brooklyn	672
	B. Bronx and Manhattan	128
	C. Queens and elsewhere on Long Island	23
	D. New Jersey	8

III. Notice of forum by:

A. Word of mouth	466
B. Bulletin boards	230
C. Publications	111
D. Individual notice (Forum mailing list)	95

The comments and suggestions were overwhelmingly favorable and indicatd the audiences' desire for more frequent meetings and for publication of the forum lectures.

The audience seemed to appreciate the opportunity offered by the refreshments to mingle socially and discuss impressions of the material presented by the speaker of the evening. The occasion served as a continuation of the question and discussion period which followed each lecture and in which the audience participated freely. The refreshments themselves, prepared by hospital workers under the supervision of Mr. Ames, chief dietitian, were served by pretty and attractively-dressed members of the student nursing classes who also supplied ushers on the floor at the auditorium. These girls received compensatory time off for their efforts and were assigned by Miss Florance R. Unwin, principal of the nursing school, who, in addition, called upon other nurses for various services, and herself supervised all the activities of the nursing staff connected with the forum.

Because of the many favorable reactions of the audience, the executive committee was encouraged to consider plans of a broader scope. It is now endeavoring to find some means of distributing printed material in connection with the lectures and is planning a more widespread publicity campaign. It seems that the community values these lectures rather highly; for the forums are being included as part of the required curricula in the psychology courses of some local colleges and schools of nursing.

The 1947-48 series comprises seven forums to be held on the first Thursday of each month with the exception of January 1948, when the meeting is on January 8, the second Thursday. The first meeting was presented to a capacity audience of 950, including standees, on November 6, 1947, with Dr. Leland E. Hinsie, assistant director of the New York State Psychiatric Institute, as speaker on the subject, "Physical Complaints of Mental Origin." Both speaker and

topic were enthusiastically received. For December, the speaker is Dr. J. H. W. van Ophuijsen, who first introduced the theories of Sigmund Freud into Holland and who now holds the post of chief of psychiatry at Lenox Hill Hospital, New York City. He is discussing aspects of Freudian doctrine. For January, 1948 we have engaged Dr. (formerly Lieut. Col.) Leon N. Goldensohn who was prison psychiatrist at Nuremberg and who is to describe psychiatrically some of his notorious patients.

The officers for this season are Dr. Julius Rubin, chairman; Dr. Joseph J. Villara, vice-chairman; Miss Ida Braiman, secretary; and Henry Girouard, treasurer. The rest of the executive committee, in addition to those named elsewhere in this article, includes Morton Lipton, staff psychologist; Miss Beatrice Gold, occupational therapist, and Joseph Sumpter, Mrs. Olive Moss, and Mrs. Josie Thompson, attendants. The Brooklyn State Hospital Psychiatric Forum will be encouraged in its endeavors as long as the interest of the community continues at its present level, which is best illustrated by a telephone call received in September from an irate woman who demanded to know why she was not notified of the first forum, believing erroneously that this season's series had already started and that she had been overlooked.

Brooklyn State Hospital
Brooklyn, N. Y.

CERTAIN PHASES OF THE TREATMENT OF INSTITUTIONALIZED EPILEPTIC PATIENTS

BY EUGENE DAVIDOFF, M. D., AND MABEL DAVIS

The Craig Colony treatment of epileptic patients includes the following aspects:

1. The mental hygiene approach which permits of a co-ordinated, prolonged program of psychotherapy, rehabilition or prevention and which includes a constantly supervised medical regimen.
2. The care and supervision by nurses and personnel specially trained in the field of epilepsy and mental illness. This phase includes the cottage system at the colony which permits the epileptic to engage in a modified self-governing, as well as regulated mode of life under skilled guidance and supervision.
3. The occupational and educational therapy programs which stimulate the patient to use his skills. This phase includes: (a) grade school for children, (b) trade school and manual training.

I. Definition and Classification of the Epilepsies

The term epilepsy is not a satisfactory designation for all the phenomena observed in seizures and convulsive disorders. It includes a number of periodically chronic recurring symptoms of neurologic and psychiatric nature associated with psychic, sensory or motor manifestations of poorly-explained genesis even though of known or presumptive origin. Often there is no organic cause which can be established definitely. The phenomena observed may be depressive and/or irritative in nature.

Spratling has referred to epilepsy as a disorder of the brain, characterized by recurrent paroxysms which are called seizures. Wilson had called these seizure manifestations, "the epilepsies," i. e., a group of symptoms due to varying etiologic factors. Lennox and Cobb have used the term paroxysmal disorders or convulsive states. Gibbs, Gibbs and Lennox have defined epilepsy as a paroxysmal cerebral dysrhythmia. Penfield has stated that the "epileptic" state is produced by a pathologic excessive neuronal disorder within the central nervous system.

Classically, seizures have been described as petit mal, grand mal and psychomotor or equivalent types. However, these divisions

are arbitrary. Frequently it is difficult to differentiate clinically and electro-encephalographically between petit mal and grand mal types. The psychomotor reactions are frequently associated with grand mal attacks, but they also may be personality manifestations of rather prolonged character.

Other less frequently encountered conditions are narcolepsy and pyknolepsy; the former, characterized by sudden attacks of compulsive sleepiness, is sometimes considered the same disorder as petit mal epilepsy, and is related by other authorities to hysteria when not symptomatic of organic disease; the latter, characterized by momentary loss of consciousness resembling petit mal seizures, is usually found in children, is transient and is not commonly considered a true epilepsy. There are also aborted aural forms (warnings), myoclonias (jerks), and atypical automatism and fugues. Furthermore, deterioration and psychoses, as well as personality deviations which are not included so often in classical descriptions of clinic practice, are encountered more frequently in institutions. Frequently, deterioration and psychoses are associated more with personality factors than with purely organic causes.

Seizures may also be classified as mild, moderate or severe, and as temporary, chronic or permanent. They may be further classified as sensory predominant (stuporous), motor predominant (convulsive), psychic predominant (mental), personality predominant (emotional or social), depressive and/or stimulative, mixed and end reactions.

Therefore, epilepsy, as we understand the term today, is not synonymous with the word "seizures." The concepts implied in epilepsy are much broader. Shanahan has stated that epilepsy is a reaction of the human body and the personality to different pathologic stimuli and that epilepsy cannot be regarded as a disease entity. Shanahan believed that the early essential feature of an epileptic seizure is an abrupt impairment of consciousness occurring often with fairly definite periodicity but that many other factors including the personality of the individual have to be considered.

From the standpoint of etiology the epilepsies have been generally divided into the two well-known groups, symptomatic (of known or organic origin), and idiopathic (of functional or un-

known origin). The writers have grouped the epilepsies as organic, functional and/or developmental. Their opinion has been that the cardinal points which serve to differentiate reversible functional and/or developmental epilepsies from the irreversible organic destructive types (non-epileptic), such as brain tumor or paresis, are periodic chronicity; diffusion of symptoms; lack of adequate structural explanation of the total picture involved in seizure phenomena or of what "sets the seizures off" and of what keeps them going"; the onset of symptoms in the earlier years of life or in childhood; and early manifestations of personality difficulties.

These concepts are indicated in the accompanying table.

Functional phenomena or psychogenic manifestations	The developmental epilepsies	Organic brain lesions
With or without loss of consciousness, or motor symptoms but with lack of integration of the personality.	Features of both organic and functional or psychologic disturbance. Presumptive causes, (organic, toxic or metabolic) may be elicited with convulsions or impairment of consciousness but a definite origin cannot be conclusively established as responsible for the *genesis* of the picture observed. The original cause does not adequately explain the total picture or the chronic periodicity. Personality development is arrested or impaired in varying degree.	With or without convulsions or loss of consciousness but with no manifestations prior to the lesion although personality deviations may be present.

In the developmental epilepsies the clinical picture emerges or unfolds as the patient's age increases chronologically, and certain personality and physiologic or physical and metabolic factors fail to keep pace with the chronologic age and with each other so that an inco-ordinate type of reaction results. A tendency to archaic or infantile patterns is often present. In the development of the picture, the total personality is most often affected but motor and/or sensory phenomena are present. The original stimulus and conditioned factors also have a bearing on the emergence of the clinical symptoms. Endocrine and other metabolic factors which require further study may enter into the picture.

In order to carry out the treatment program, epilepsy should be classified from the therapeutic and prognostic standpoint. In other words, what possibilities in treatment does each individual epileptic present? What are his assets and liabilities and how much can be expected of the treatment program? Therefore, the patients are first classified as Shanahan has indicated into the temporary, prolonged or permanent types of various degrees of severity, i. e., mild, moderate or marked. The patients are also segregated in accordance with age and sex.

For the purpose of instituting a practical program of treatment with special reference to the occupational therapy and nursing activities, the patients are further subdivided as follows:

1. The uncomplicated or average epileptic patient or the mildly handicapped.
2. The handicapped epileptic (moderate or severe)
   - A. Physical or organic
   - B. Emotional (with psychogenic factors or asocial personality)
   - C. Antisocial
   - D. Mental defective (with or without physical or emotional handicaps)

The adults are segregated from the children in almost all instances. The patients, except for markedly disturbed, defective or deteriorated, are allocated into treatment groups according to their chronologic ages as indicated here.

1. Children and juveniles
   - A. 1 to 6 years
   - B. 7 to 12 years
   - C. 13 to 16 years
   - D. 16 to 18 years
2. Adults
   - A. Young group (18 to 25)
   - B. Middle group (25 to 40)
   - C. Older group (over 40 years of age)

The patients are classified for treatment purposes in accordance with their intelligence quotient and achievement or performance capability, their social adaptability and their emotional stability.

II. The Diagnostic Routine

All patients received at the colony have complete mental and physical examinations, including chest x-rays, Wassermanns, immunization series, etc. As complete a history is taken as circumstances permit. Other technical and laboratory examinations are ordered when they are indicated. An electro-encephalogram has been done on the majority of patients admitted within the last six months. Skull x-rays as well as roentgenograms of the bones and joints are frequently ordered.

These patients are closely observed in the reception service for approximately two weeks. Complete records are kept of their physical and mental conditions, their behavior and the number and type of seizures. During this period the standing orders for necessary medication and nursing procedures, medications and anti-convulsant drugs, such as phenobarbital and dilantin, are carried out. Unless toxic effects are observed, or there are other reasons, the patients usually receive the same anti-convulsant medications as they did prior to their arrival at the institution. This is done because convulsions of alarming frequency and severity may often ensue if drugs such as phenobarbital or dilantin are abruptly discontinued. If it is necessary to withdraw these drugs, this is done gradually. The patients are then classified as indicated in the previous section.

Following assignment to cottage, ward or industry, this routine is continued. The patients are observed by physicians, nurses and attendants. Their physical conditions, seizures and behavior are carefully charted. Necessary changes in diagnosis, occupation, classification and treatment are made if and when indicated.

III. The Treatment Program

A. *Psychotherapy.* The various phases of the treatment consist of a well-rounded co-ordinated mental hygiene program which includes individualized care of each patient, psychotherapy, adequate nursing supervision, stimulation of interest, occupational and recreational activities, education, re-education, rehabilitation and finally drug therapy. None of these phases of the treatment are carried on alone but are part of an interrelated whole.

The psychiatrist, of course, supervises and co-ordinates the treatment procedure. He prescribes the therapy, usually after conferring with the other departments concerned in the care of the patient.

His primary mission is psychotherapy. He applies the time-honored psychotherapeutic procedures such as ventilation of conflicts, reassurance, suggestion, advice with respect to the patient's individual problems, relaxation, reconditioning and outlining the program to be followed. He evaluates the history, the mental and physical status, the patient's personality, his assets and liabilities. He indicates what can be expected of each individual patient and what can be done to render him socially adaptive.

The patient is stimulated to use his assets, to overcome the handicap imposed by the disease and to adjust socially. He is made to feel that he is not different from others, that he is a human being and, as such, he is subject to infirmities which other human beings possess in varying degrees or in the different aspects of their personality make-ups and physical make-ups. He is made to realize that he can help himself and stand on his own two feet by engaging in a judicious mode of life. He must avoid certain things which are inimical to him in the same manner in which a diabetic is watchful of his diet, or a neurotic is mindful of certain occupations or situations which bring forth certain unresolved complexes and are prejudicial to his emotional stability at a given time. In the event of improvement or resolution of his conflicts, he may allow himself more latitude, even though he is watchful of emotional or other stimuli which are not beneficial to him. However, he must be convinced that there are many vistas open to him and that there are many activities and modes of occupation in which he can engage. A hopeless or "I am shut out" attitude is unnecessary and harmful.

B. Drug Therapy

The psychiatrist's secondary mission is to prescribe drug therapy. However, anticonvulsive medications *per se* when administered without the aid of a mental hygiene and psychotherapeutic program have proved unsatisfactory in the control of the total epileptic picture.

The type and dosage of anticonvulsant drug employed and the method of administration vary with each patient and his individual characteristics. Some react better to drugs given in combination. There is no drug that can be considered specific for epilepsy. No form of pharmacotherapy has adequately controlled the grand mal seizures which are most often encountered in institutional practice.

Phenobarbital, given in doses of one and one-half grains two or three times daily is still the most frequently used drug at Craig Colony. A few respond well to other barbiturate derivatives. The patients must be watched for dullness and drowsiness. About 20 per cent of individuals who did not respond well to phenobarbital reacted better to dilantin alone or in combination with phenobarbital. Dilantin is also given in doses of one and one-half grains, two or three times daily. The patients are watched for untoward effects such as gingivitis, or ataxia, etc. Mesantoin, which is said to be less toxic, has recently been used but it is too early to judge the value of this drug. It apparently has a beneficial effect on grand mal seizures and can be given in larger doses than dilantin. Initially .16 G. three times daily is administered. As high as .6 to .9 G. can be given daily.

At times, some patients respond better to phenobarbital (gr. 1½) and bromides (gr. x) two or three times daily than to either of these given alone. Glutamic acid and the ketogenic diet have not yielded very satisfactory results. Potassium borotartrate solution, given usually in doses of one drachm two or three times daily, is effective at times.

Tridione requires further study, but preliminary observations would indicate that it is of value in children suffering from cerebral palsies and in the milder forms of symptomatic or idiopathic epilepsy. Children with idiopathic epilepsy whose attacks have been of recent onset and of the petit mal type, react fairly well. Those who manifest psychomotor seizures improve in about 50 per cent of the cases. The usual dosage is 0.36 G., t. i. d. Untoward effects have been noted in about 25 per cent of the patients. In grand mal seizures, the results with tridione have been unsatisfactory.

The treatment and/or aborting of status epilepticus and serial seizures is one of the emergency situations in which the prompt administration of anticonvulsant medication is necessary to prevent serious sequelae or fatality. The early appearance of premonitory signs, such as a severe jerking in a person known to have had status epilepticus or the appearance of two seizures in rapid succession should be reported by the nurse to the physician as soon as possible. Serial seizures or status epilepticus in the early or milder stages respond well to the subcutaneous injection of sodium luminal (5-10 grains). In the more severe phases, sodium amytal (15 grains) or delvinal sodium vinobarbital (5-10 grains) are administered by the intravenous route. At times, inhalation of chloroform may stop status epilepticus or serial seizures.

IV. The Nursing Program

During the quarantine period, the nurse aids the physician in close observation and proper classification of the patient. This study by the nurse is continued throughout the patient's residence. The degree of supervision depends on the type of case.

It is very important that the nurse watch the patient's mental attitude and personality in action. By assuming a calm, understanding and objective attitude, the nurse contributes to the mental hygiene approach to the patient and aids in treatment and proper placement of the individual.

Habit training and re-training are part of the nurse's assignment. She sees to it that the patients are kept busy, as it has been found that epileptic patients benefit by any constructive activity which awakens their interest and keeps them occupied. So that male patients receive adequate medical nursing and psychiatric care, it is necessary that men nurses be employed to assist in carrying out a well-rounded program.

A. *Physical Care*

Following assignment to the cottage and industrial group to which the patient is allocated, a continuous nursing history chart is kept with regard to occurrence of illnesses or injuries, general physical welfare, weight, number and types of seizures, emotional

upsets, and medications received. Reports are also received from the industrial group in which the patient is placed; and the reaction to, and adequacy for, the assignment are noted.

The treatment of each patient must be individualized to meet his particular needs. The program, therefore, is varied. The patient's physical assets and liabilities must be considered. The nurse assists in special procedures of surgical and medical nature, including hydrotherapy and physiotherapy.

Other procedures necessary for the physical care of epileptics include the treatment of seizures, or treatment in the emergencies which may arise, the prevention of injuries and general supportive measures. For further discussion of these specialized aspects of nursing-care in epileptic patients, the reader is referred to the paper of Doolittle, Vallone and Greene on this subject.

The necessity of adequate nursing care for the severely handicapped cannot be sufficiently stressed. The supervision of the imbecile, idiot or severely deteriorated adult patient is similar to that of the severely handicapped bedridden child. Constant care of his physical needs, supportive treatment and habit-training are important. Special dietary and feeding procedures, prevention of intercurrent infections, injuries and bed sores, in the ambulant as well as the bedridden, are some of the aspects which require specialized nursing supervision. The frequent changing of, and the habit-training of, the wetting and soiling present another problem.

B. *Mental Care*

Doolittle, Vallone and Greene have stated "In harmony with the psychologic viewpoint of epilepsy, the principles of mental hygiene are practiced in an effort to assist the epileptic to modify his habits of living in order to attain a maximum degree of emotional, mental and physical health. Many situations arise which tax the nurse's ingenuity and resourcefulness.

"The epileptic frequently presents symptoms of emotional or social maladjustment. He may be sensitive or aggressive. The nurse must possess sufficient understanding and sympathy to adjust herself to the patient rather than expect the patient to adjust himself to her. She should endeavor to control him by tact to prevent injury to the patient, herself and others. The nurse should

not show irritation. She should be understanding, courteous, quiet and reassuring but firm in her manner.

"The patient may bring many of his problems to the nurse as well as the physician for help in their solution. At times, understanding, a readiness to listen, and a simple explanation on the part of the nurse is all that is needed to help solve some patient's difficulties. The nursing treatment is often directed toward the best adjustment of the individual toward his malady."

The nurse should be able to assist the physician in caring for the patient's emotional problems. She must also learn to help the physician allay the anxieties of relatives and to explain adequately unpleasant circumstances or situations. The prolonged care necessary for many individuals, the difficulties encountered or the poor prognosis should be discussed tactfully and courteously with the relatives after the physician has interviewed them.

Specially-trained attendants and personnel assist the nurses in the Craig Colony cottages. They aid in stimulating the patient's adjustment to group life and in effecting a healthy mental attitude toward his handicap.

Summary of the Nursing Program

Because the nurse knows something of the patient's personality, his handicaps, his assets and his physical stamina or limitations, she assists in the planning of the therapy program including occupational, recreational and group activities. In short, the nurse aids in the treatment of the patient's physical disability or his emotional difficulties and assists in his social adjustment.

The Occupational Therapy Program

The occupational therapy department functions as part of a team. It works in close co-operation with the nursing staff and all other departments in a co-ordinated program of mental hygiene under the direction of the psychiatrist.

The total program is designed to help the patients to live together; to feel themselves acceptable by the group; to develop their abilities; to overcome or minimize their handicaps; and to adjust to their environment.

The occupational therapy department seeks to plan a balanced day of work and recreation adapted to the patient's needs. For this purpose the patients are divided into the chronologic age groups mentioned in Section I, i. e., young children or juveniles and younger or older adults.

Each age group is again subdivided according to the degree and type of epilepsy or associated handicap, the patient's physical condition and his mental age as indicated in Section I. That is: (1) Patients with normal or nearly normal mentality or personality-structure and without physical disability and/or those only mildly handicapped. (2) Moderately or severely handicapped patients with (a) physical disability, (b) emotional difficulties, (c) social maladaptation or antisocial traits and/or (d) intellectual impairment.

The manifestations in the handicapped groups frequently overlap. The moron or borderline-defective epileptic may frequently be antisocial. He frequently presents emotional, personality and behavior problems in addition to mental deficiency. The emotional epileptic patient may present antisocial as well as asocial difficulties. The physically-disabled patient may present many emotional problems associated with his "invalidism."

The graded occupational therapy program begins at the reception building almost immediately after the patient has been admitted. The physician examines the patient and tentatively prescribes the occupational therapy treatment to be given. During this period of observation in the reception service, orientation talks are given to the patient with regard to the function of Craig Colony, of occupational therapy, the school, the churches, the libraries, and the many kinds of recreational activities. The therapists use this time to become acquainted with the patient, to gain his confidence, and—after conference with the physician and nurse—make appraisal of his needs. Games and books from the library are the first things provided and such handcraft as may be done on the ward, if the patient desires it.

After the patient is assigned to his cottage or ward, each one, depending on the group or type in which he is allocated, then engages in the occupational therapy program. This includes the following: (a) constructive pursuits, (b) program for leisure time which

includes recreation, relaxation, physical activity and participation in group activities.

(1) *The program for the non-handicapped or only mildly handicapped epileptic patient*:

Every patient who is mentally and physically able receives something constructive to do and some work for which he or she is responsible. For adults, the activity may be in some branch of Craig Colony's industries such as the print or tailor shop, store or laundry. Children under 16 years of age engage in the constructive program of the colony school. The occupational therapy department assists these persons in stimulating their interests in the various types of handcrafts during their leisure time. For the woman, these handcrafts include stitchery, lace-making, toy-fashioning (such as dolls or animals), shell jewelry, leather work, block printing, drawing, painting (water colors), weaving, knitting and plastics.

Adult female patients enjoy the type of handcraft with which they are familiar or which they associate with home, such as stitching, knitting or crocheting. The younger women and girls like to learn new handcrafts and to make things with which to adorn themselves such as shell jewelry, woven scarfs and crocheted hats. Frequently they form sewing circles in their leisure time and have informal evening or afternoon "luncheons."

The handicraft program for men includes carpentry, painting, weaving, such as the floor loom or the braid (upright) loom, leather work, metal tapping, bookbinding, printing or block printing, and plastics. The younger male patients, even those somewhat physically handicapped, enjoy carpentry. They like to do constructive "building" of such articles as boxes, stands, and foot stools. They also like to weave rugs. They either use in their cottages the objects they have made or send them to their relatives. The boys also favor articles which they can wear or carry, such as braided chains and belts.

Active recreation at the colony consists of: a. Competitive group sports, such as basketball, baseball, and volleyball. b. Individual sports such as horseshoe pitching, roller skating, tumbling, pyramid building, badminton. c. Group or community activities such as hikes, picnics, social dancing, music and operettas. d. Games such as cards, jig-saw puzzles and checkers.

Passive recreation includes movies, listening to music, and watching sporting events. All the patients receive recreational and physical instruction from therapists well trained in directing these activities. Competitive group or team sports wisely directed, including baseball and basketball tournaments, tend to bring out constructive personality traits and to build up feelings of self-reliance, good sportsmanship, security and satisfaction. There are few games or sports which are denied epileptics, particularly those physically able to participate.

Patients seldom have a convulsion while engaged in physical activity upon which their attention is focused. However, since it is possible for seizures to occur at any time, such activities as bicycling, climbing to a high elevation, tending fires at picnics, etc., are usually prohibited.

A planned program of recreation and occupation is an integral part of the graded occupational therapy and mental hygiene program. Since all of the patients, even the well adjusted, have some psychogenic factors present, recreation and occupational therapy are valuable therapeutic adjuncts.

2. *The moderately or severely handicapped epileptic patient.*

While the occupational therapy activities concern themselves with all the patients, the program is particularly helpful to, and is designed to meet the needs of, the moderately physically, mentally or emotionally handicapped. It is in the rehabilitation of incapacitated children, young adults with cerebral palsies, and patients of moron or borderline intelligence that the occupational therapy department has been of great value in the treatment program at Craig Colony. It is on this phase of the program that the occupational therapists are concentrating a great deal of their effort in co-operation with the physicians and nursing staff.

Some of these patients receive treatment in the occupational therapy centers—to which they come unattended. However, the more severely handicapped are first sent to closely-supervised wards which they may not leave unless attended. Occupational therapy and recreational therapy are brought to these patients. There may be a considerable difference in the range of symptoms and degree of severity of the intellectual, emotional or physical handicaps in these individuals.

Adults who possess neurotic traits and cannot work consistently in industries, or emotionally immature children who present many conflicts or who cannot concentrate on their school work, are frequently referred to occupational therapy to engage in a program of constructive activity. Those who are more severely upset and require more constant care, are treated in closely supervised types of buildings. Patients who require considerable guidance are treated in a moderately-supervised type of building. If the more severely handicapped patient improves, he is transferred from the closely-supervised group to the less closely-supervised ward and from there, if his condition warrants, to the open cottage and occupational therapy centers.

A

For patients with normal mentality and moderate physical disabilities such as are observed in some children with cerebral palsies, much of the program is the same as for the non-handicapped. However, it is modified in some respects to meet their physical and emotional needs.

The "work responsibility" part of the program is generally the same as for the individual without handicap except that the occupation chosen is graded with respect to the degree of disability. However, a real job assignment within the limits of the patient's physical capabilities is given. If the patient is of school age he engages in the modified scholastic program of the colony grammar school. If an adult, he might be assigned as helper in the linen room, worker in a cottage day room or messenger.

An individualized program of physical rehabilitation and remedial exercise applicable to their handicaps are prescribed for these physically incapacitated patients. For example, a child with cerebral palsy receives massage, passive and active exercise followed by remedial occupational therapy in which the handcraft or occupational activity is so adapted as to foster joint and muscle motion of the handicapped part and improve co-ordination. In addition the program stimulates new interest. In the handcrafts these physically incapacitated males enjoy carpentry even though they may be so handicapped that they have to put the wood in a vise, and saw or plane with one hand. Remedial exercise, particularly in younger individuals, is alternated with frequent rest periods or change of activity such as music, games, or story telling.

B

Patients with emotional handicaps (psychogenic factors and asocial personalities predominating).

These symptoms are at times found in psychomotor or equivalent reactions. Frequently they are part of a personality pattern which is distinctly neurotic or associated with defective integration of the personality.

Among the moderate manifestations are included emotional upsets, anxiety, crying spells, psychosomatic manifestations, conversion phenomena, or hysterical outbreaks, as well as moderate compulsions and phobias. Among the more severe manifestations one finds tantrums, suicidal ideas, severe compulsions and phobias, depression, hypomanic-like activity, schizoid personalities and psychotic or psychotic-like behavior. Of course, the more severe cases frequently do not respond well to any type of therapy. At times, however, a surprising degree of adaptation, particularly at a restricted level, can be stimulated in some.

Frequently the degree of severity of the emotional or social problem is not a measure of the severity of the seizures. Many patients who have severe seizures can be handled easily if they possess only a slight degree of personality difficulty or antisocial behavior.

The psychotherapeutic program concerns itself with activity that will wear out and abreact the affect, stimulate constructive pursuits, and thus ultimately sublimate these neurotic drives into creative accomplishments. After joint interviews with the psychiatrist, the occupational therapist plans a program of balanced work and play which includes handcraft that will interest the patient, give him the satisfaction of accomplishment and afford recreation and group participation. Activities which both stimulate him to do things and relax him are recommended. In the case of children, considerable guidance as well as reassurance is indicated.

C

The antisocial group:

In antisocial patients the problem is much the same as in the emotional group, as many of the mechanisms and manifestations are similar. Moreover, this type presents a more difficult problem administratively because of destructive aggressive behavior which

is directed against the group. In some of the more severe cases, very little can be accomplished if a definite antisocial or poorly-integrated personality pattern is present. Frequently these prolonged antisocial or asocial types are very closely allied to the psychotic group. However, in the moderate group where the excitement or equivalent reaction is more intimately related to the seizures (as in the so-called psychomotor reactions), proper understanding, adequate nursing and psychiatric care and the combined efforts of the physician, the housemother, the occupational therapist, the nurse, in other words the entire personnel of the colony, can assist in making an adjustment.

D

The mentally defective group:

Mentally defective patients are received at the colony in all age groups and with varying degrees of handicaps—physical, social and intellectual. Therefore, a great many of these patients are subdivided and treated as outlined under the foregoing headings (2, A, B, C) depending on the predominant associated limitation.

It is the aim of occupational therapy to help this type of patient to learn to make the best use possible of his limited mental and physical endowment. In younger individuals where the mental deficiency is due to deprivation or environmental factors, an attempt is made to overcome these influences and stimulate the patient to approach intellectually normal performance.

Children and juveniles not accepted in the Craig Colony grammar school are admitted to occupational therapy classes. These usually include youngsters with intelligence quotients under 50 or with mental ages under six years.

The program is one of planned character-building. The aim is to teach the young individuals to work and play together, to take care of themselves and their clothing and to respect the rights of others.

The following is a résumé of the typical morning activities of the moderately-defective epileptic child or juvenile:

(1) Morning inspection—Includes instruction in personal care and hygiene such as cleaning teeth and fingernails, brushing hair, tying shoelaces and buttoning clothes.

(2) Table activities—Include manual work adapted to the degree of deficiency. For boys the activities are tying loops, sanding, leather work, lacing, crayon coloring, etc. For girls—sewing, mending, paper cutting, coloring, etc., are part of the program.

(3) Supervised play—This has as one of its purposes, along with others previously mentioned, the achievement of good sportsmanship. The children learn to take turns, to be good losers and to cheer their opponents.

(4) Free play—This gives to the patient some sense of responsibility and gives the workers a chance to observe the child. It, at times, results in an attitude of co-operation and unselfishness on the part of the mentally-defective child.

(5) Story telling—This broadens children's interests and encourages memory training.

(6) Music appreciation—This includes singing with or without phonograph records, rhythm band and musical singing and marching games. It stimulates group adjustment and improvement in co-ordination.

(7) Hikes—In addition to the physical aspects, this activity permits further study of the patient, encourages him to be more alert and observing and stimulates the patient's social adjustment.

In mentally defective adults, antisocial and asocial personality manifestations are pronounced and frequently found. Often in the more severe types a great degree of physical incapacity is present. They are usually assigned to wards or cottages according to the degree of deficiency and/or associated handicaps, in the following manner:

A

Borderline defectives are housed in open cottages and have ground privileges. The treatment regimen approximates that of the normal.

B

Moron patients are housed in open cottages and have restricted ground privileges; they are under more supervision. Often, particularly in the early period of their residence, they are unable to adjust sufficiently to work in any of the hospital industries. They may have severe seizures. Some may be irritable, quarrelsome and aggressive. Others are apathetic and display little interest. The

occupational program for these patients consists of a full day of sedative manual activity. This is usually in a craft in which they show some interest and ability, as well as active and passive reactions. After a trial period, if they adjust better, they have more privileges. Not infrequently they are able to take a useful part in the community life of the colony.

C

The severely-excited, assaultive, overactive, confused or suicidal mental defectives are housed in closed wards. They are problems in nursing and medical care. However, a percentage of these are visited by occupational therapists or visit the closed occupational therapy center and do handicrafts when their condition permits. They engage in simple games and are taken for walks. They are closely supervised and are not permitted to use any tools. At times some of these patients who are destructive on the wards are quieter during the occupational therapy period and fairly industrious.

(3) *Miscellaneous group*:

(a) The severely physically and mentally incapacitated. The wheelchair and bed or crib mentally-defective patients are primarily problems in nursing care. Their treatment was outlined in the section on nursing program. However, music and simple recreational activities are brought to these patients. The children receive toys and adults have simple handicrafts adapted to their limitations, such as stitching or raveling.

(b) Deteriorated patients are treated in the same manner as the mental defective or un-co-operative patients mentioned in the foregoing.

(c) Patients with serious seizure phenomena are problems in nursing care. Depending on the age and associate manifestations, occupational therapy is brought to them or they attend occupational therapy in the interims between seizures and engage in a modified program. The adults at times are assigned to simple industrial tasks in which they are carefully supervised. The children frequently engage in a closely-supervised school program if their mental condition permits.

SUMMARY OF THE OCCUPATIONAL THERAPY PROGRAM

In none of these groups does the occupational therapist work alone. The successful application of occupational therapy can only be brought about by good team-work and adequate medical and psychiatric supervision. All persons with whom the patient comes in contact must work together. The psychiatrist prescribes the treatment. The nurse adds warm personal encouragement and good advice, as well as adequate nursing care. The house-mother shows interest and co-operation in getting the patient to his classes.

The other personnel add their approval in one way and another so that the entire program provides a good working background against which the patient, even though handicapped, can emerge confident, hopeful and secure in the realization that he is constructively occupied and is accepted by his fellows. In severely-handicapped or deteriorated patients, habit training, supervised care and a mild degree of rehabilitation which enables the patients to care for some of their own needs, are frequently all that can be expected.

ILLUSTRATIVE CASE ABSTRACTS

The first presentation is an example of the occupational therapy program with respect to a fairly well-adjusted epileptic child who presented some psychogenic factors.

Case 1

E. F. was admitted to Craig Colony on court certification March 8, 1939, at the age of 10. Her mental age was 11 years, three months, and her I. Q. was 109.

Family history. Her mother is living and was 39 years of age when E. J. was admitted. The patient was reported born out of wedlock. Her paternity was never established.

Personal history. The patient was born June 11, 1930. She was a strong baby and weighed nine pounds at birth. Teething commenced at three and one-half months and she began to "take notice" and sit up at six months. She walked at nine months and commenced to talk at two and one-half years. She was described as a shy girl who did not show much interest in affairs outside her home and was apparently coddled by her foster parents. She

made a fair scholastic adjustment but did not mingle much with her schoolmates.

History of epilepsy. The history states that the first seizure occurred in 1933 when she was three years old. At that time the patient was being removed by her foster mother from a boarding home where she had been placed since birth. It was necessary to travel by rail and during the trip the child had six seizures in rapid succession. The foster mother thought the child was frightened because she was being removed from her previous surroundings. (The social worker's report intimated that possibly the foster mother may have been the paternal grandmother).

The second attack occurred one month later. Afterward she manifested convulsions about once a week. She received phenobarbital for her seizures. At first they were petit mal in character and she showed some improvement. Later grand mal convulsions developed and she occasionally bit her tongue. She apparently lost consciousness at each attack. Because of her foster mother's inability to cope with the seizures in her small quarters and because of financial stress, the patient was removed to an orphanage late in 1938 when she was approximately eight and one-half years old. There the patient became steadily worse. The attacks were more frequent and severe, increased to about three a week, and at times she experienced six a day.

Accordingly, the patient was admitted to the female reception service at Craig Colony. Her physical status except for seizures was normal.

Mental status on admission. The patient was quiet, co-operative and friendly with the physicians, nurses and occupational therapists. Emotionally she was easily upset, was self-conscious, did not mingle much with other children and lacked confidence in herself. Her thought processes were average. Her actions were rapid and well co-ordinated. Her attention and retention were good. She was oriented in all three spheres and was of average intelligence. She had reached the fifth grade in school. She was neat, well-behaved and willing to do things. She was helpful and handy.

The diagnosis was idiopathic epilepsy—unclassified (possible etiology—psychogenic factors).

The patient was visited in the admission building by the occupational therapist and the physical therapist immediately upon arrival. She was somewhat self-conscious but enjoyed the company of older people. She did not get along well with children her own age and did not seem to know how to play with them.

She enjoyed the handwork and started making an embroidered organdy pillow top while in quarantine. Later, after the quarantine was over and she was admitted to the school, she voluntarily continued her handwork in the occupational therapy department after school hours. She was encouraged to do this because she was somewhat retiring; and it was wished to gain her confidence and stimulate her confidence in herself. Because of her shyness and lack of ability to mingle with children her own age, she was placed in a small, special group in the reception service where the physicians, the nurses and the occupational therapists could observe her closely and work more intimately with her.

Her response to recreation and physical instruction was slow. At first she was too shy to join in games and singing with other children of her own age. Her posture was very poor and her shoulders stooped. She manifested feelings of inferiority and insecurity. She attended the routine posture-training and general physical education classes regularly, but had to be coaxed to attend the recreational activities which were selective, i. e., group games, competitive sports, roller skating, and tumbling.

Each fall the patients start rehearsals for the Christmas operetta which is the major dramatic production of the year and in which all the well-adjusted patients participate.

E. F. had a part in a chorus with six other girls her size. She went from the recreation hall quite happily with the other children. She had no seizures while actually taking part in the rehearsals, or on the stage on the night of the performance.

Her seizure record at the institution for nine months following her admission in 1939 revealed 24 grand mal and 16 petit mal attacks. She continued to be somewhat self-conscious. She enjoyed social dancing with the instructor in a small group. It was several months before she was persuaded to attend the dances given for the patients in the large recreation hall and to get out on the floor with the other dancers.

Early in 1940 the patient was transferred to the children's cottage. At the cottage she was quiet and well behaved. At first she had little to do with the older girls. She seemed to irritate the children of her own age, although she was always kind to the little ones.

She was encouraged to join the Brownie troop of girls preparing to be Girl Scouts. She was responsive and alert and was soon promoted to the Girl Scout troop. She took an active part in scout activities, enjoyed hiking, nature study, singing games and craft work. She was well liked by the other scouts.

Gradually she became accustomed to taking part in the group activities. She joined the glee club and took longer parts in each dramatic production. She learned to play tennis and to roller skate. She became so proficient on roller skates that she learned to dance a simple waltz on her skates. Later she mingled very well with the other children, was well liked and became a leader in their activities.

In 1941 E. F. was considered to be making a very good adjustment. Socializing activities were continued throughout the year. In school the patient was placed with the class of students with normal I. Q., and in 1941 she passed her state regents examination.

After her graduation from the colony school, E. F. was employed as a domestic at the home of one of the physicians. This is considered by the patients to be one of the most desirable assignments in Craig Colony. She worked regularly, was neat and efficient, and her efforts were considered very satisfactory. She helped the nurses in the cottages and was given responsibility by them. In addition, she took an outstanding part in the recreational activities of the colony and was well liked by everyone.

Her seizure record shows an average of 20 grand mal convulsions a year. Previous to admission she had about 160 per year. She has made an excellent social adjustment. On July 30, 1946, she was taken on convalescent status by her foster parents.

* * *

The following two case summaries are illustrative of the occupational therapy program in treatment of moderately handicapped children. Case 2, (R. J. H.) is that of a nine-year-old boy handi-

capped by cerebral palsy. In the abstract of Case 3, the procedures employed with an emotionally immature, apparently inadaptable seven-year-old girl of borderline intelligence are presented.

Case 2

R. J. H., a nine-year-old boy, suffering from spastic paralysis, was admitted to Craig Colony on October 29, 1945.

Family history. Mother and father are both alive and well. The father, after discharge from the army did not return home. He was frequently unemployed and there had been much dissension in the home. The patient was the older of two siblings. His younger brother is well and presented no problem.

Personal history. The patient was born June 26, 1936. He was delivered by forceps and received a birth injury which involved both the temporal and frontal areas of the skull. The patient did not have convulsions immediately after birth, but seizures were first manifested at the age of three. He first walked and talked at two years of age.

R. J. H. had been treated previously in a clinic and hospital for children with orthopedic conditions from 1939 until 1945. The following is an abstract of their report: The diagnosis was cerebral spastic paralysis associated with birth injury, with involvement of the lower extremities and slight involvement of the upper extremities.

At first, treatment consisted of muscle training and shoe wedges. However, it was noted that he continued to have an internal rotation deformity of the lower extremities and on November 19, 1941 a bilateral Durham procedure was done. He was then transferred to a convalescent home on December 8, 1941.

He returned to the orthopedic hospital April 29, 1942. Examination revealed a diminution of the internal rotation deformity. Again he was sent to the convalescent home for training in walking and for routine care.

His last admission to the orthopedic hospital was on December 3, 1942 and muscle training was continued. Since his discharge from that hospital he was followed in its clinic from time to time. On January 24, 1943 a note was made to the effect that the mother was having trouble with him from a behavior standpoint.

He was moody and could not get along with his brother. His I. Q. rating (90) showed him to be in the normal group. The patient was last seen in the clinic on June 6, 1945 at which time his mother was quite concerned about getting this boy into "some sort of a home." She stated that she was unable, by herself, to supervise the boy and give special training to him.

Examination at this time revealed that the patient walked with a moderate type of scissors gait. Knees were maintained in slight flexion and feet in pronation and equinus. Due to the great difficulty he had in walking, resumption of walking exercises, as well as heel-cord stretching, was recommended. It was not believed that any operative procedure would greatly improve this boy's condition.

R. J. H.'s mental development was slow; but apparently by the time he was six years of age it approximated normality. However, because of his physical disability and his lack of interest, he appeared much duller than he actually was. He first attended school at six and completed third grade.

History of epilepsy. The first attack occurred at about three years of age. The succeeding attacks occurred at intervals of about six weeks. They were mild and motor in character and occurred mostly during sleeping hours. The greatest number in any one 24-hour-period has been two. He had had dilantin and phenobarbital in the treatment of his epilepsy. He is left-handed and can care for himself wholly. In the year prior to admission he manifested grand mal seizures about twice a month.

Admission note. He presented a problem in both social and physical adjustment. He came from a "broken" home. His father, after his discharge from the army, not only did not return to his family but did not contribute toward the support of his wife and children after the army allotment stopped. The mother said one reason for bringing the boy to the colony was because "the other children did not accept him;" he was "moody" in the home and he did not get along with his younger sibling. Physically he was handicapped by an internal rotation of both lower extremities (scissors gait), so severe that he was continually falling. He tired so easily and his muscular co-ordination was so poor that he could not walk the distance from his cottage to the school or even to the

occupational therapy department buildings which are a little more than the distance of two city blocks way. He would frequently fall after walking 20 yards.

The diagnosis was symptomatic epilepsy, due to cerebral birth injury.

The electro-encephalogram revealed bilateral motor (parietal) involvement, and the x-ray showed a deformity of the parietal bones. The patient was referred to occupational therapy February 1, 1946 on prescription from the doctor. A full morning of closely supervised occupational and physical therapy was followed by school studies in the afternoon. At first the physical instructor transported R. J. H. in his car from the ward to the occupational therapy building each morning. Later two patients assisted him to walk to and from the ward.

The mental status and physical instructor's notes following admission revealed the following: "The patient is nine years old and slightly under normal in size. He reached the third grade in school. He walks with bent knees and on his toes with his lower extremities inward. The left foot appears weaker than the right. His co-ordination is poor. The weight is carried forward and he has a tendency to run rather than walk. The patient is afraid others will not approve of him, is timid, cries easily and has a tendency to play by himself but will often play with older, more intelligent children who are painstaking and attentive to him. He is co-operative but not overly ambitious and at times gives up rather easily."

The patient was massaged daily and was continually reminded by the instructor to push heels down and toes out. He had the following active and passive exercises: (1) deep knee bends, (2) side leg-raising, (3) push-ups, (4) supine arching, (5) foot touching, (6) toe touching, (7) use of chest weights.

R. J. H. bounced and threw a rubber ball against the wall; played catch; tossed bean bags and used specially-constructed toys for improvement in manual function.

Two months later, the notes showed that the patient continued to walk on toes with the lower extremities rotated inward, had some difficulty in walking down stairs and fell at times while walking on the level. However, he showed some improvement, was over-

coming the "pushed forward" position and running gait and, therefore, fell less frequently. He continued to do the same exercises as in the previous report. He showed some improvement in physical co-ordination and in use of the rubber ball. He was unable to skip rope, either alone or with aid of two other persons. His co-ordination was fair but his balance was still poor.

In July 1946 it was noted that the boy's ability to walk had improved a great deal. His co-ordination and balancing were better. He could walk greater distances without falling but still had a tendency to tire easily.

Occupational therapy notes stated that the patient was co-operative and obedient and seemed to enjoy the class periods. Hand and floor loom weaving were first given to supplement his corrective exercises. Weaving is a bilateral craft which, as adapted for R. J. H., necessitated balance, co-ordination, flexion, extension and rotation of upper extremities, flexion, extension and outward rotation of lower extremities. He first had a small two-treadle foot loom. This he learned to operate rather easily and in six weeks was weaving with moderate success, doing all operations except rolling. He showed interest and co-operated well. He was then transferred to a larger loom with less steady treadles. The larger loom required greater concentration and co-ordination, extended reach for shuttle and beater and increased outward rotation of the lower extremities. During the three-hour daily occupational and physical therapy periods, the program was varied to include music, competitive games and crafts.

In July 1946 the occupational therapy notes stated, "R. J. H. likes to play with the other patients and is a good sport about losing. He has won at the competitive games in the class program several times. The patient seems to tire easily and cannot do more than four or five rows of weaving at a time without resting. While he rests he is given some small table activity, for example, a small leather purse. He learns fairly easily. He has been able to do braid-weaving and can tie loopers."

At the present time, the patient is showing improvement in his physical condition. He is able to walk unassisted from his cottage to the school, the athletic field and to the O. T. center. These distances range from 600 to 1,200 yards.

Socially, the patient seems to be making a good adjustment. He is friendly with the other patients and is liked and accepted by them. He does not tire as easily and only occasionally seems disinterested. R. J. H. does not cry as he frequently did. He seems happier at his play and in doing his exercises. There has been a gradual improvement in his attitude.

This patient is receiving tridione as one of a special group of spastic children. Under this treatment program, the combined efforts of the psychiatrist, the nurse, the occupational therapist and the physical instructor, R. J. H. has had fewer seizures. He is walking sufficiently well to go about independently for gradually increasing distances and socially he is developing a normal pattern for a 10-year-old boy.

His 1946 seizure record shows two grand mal seizures in January and one in June. There were no seizures noted in February, March, April, May, July or August.

Case 3

M. S., a borderline defective girl with an I. Q. of 70, who manifested emotional difficulties and antisocial behavior, was admitted to Craig Colony on May 11, 1945 at the age of seven.

Family history. The patient is the third of seven siblings. The mother was in Rome State School. The father also was described as a person of low intelligence. There are two mentally-retarded siblings. The paternal grandmother was mentally defective.

History of epilepsy. The patient's history revealed the fact that she had had grand mal seizures since the age of five or for two years prior to admission. These began following the death of her father. During attacks, she wandered away and became confused. Her memory was poor and she was exhausted after seizures. Previous to her arrival at Craig Colony her seizures increased and she had as many as three a week. The social worker reported that the child never seemed to comprehend things, was slow in tests and co-operated poorly. She could not be taken care of at home because of her behavior. She was destructive, "touchy" and excitable. She cried a great deal, was fearful and apprehensive. In addition, since her father's death, her mother, who was defective and in poor circumstances could not take care of seven children adequately, and she rejected this child.

On admission, M. S. was classified as a case of idiopathic epilepsy, with psychogenic factors in a mental defective with poor familial background. Following admission, under the close supervision of the quarantine period, she at first caused no difficulty and seemed pleased by the change in her surroundings. During the "getting acquainted time," with the occupational therapist and the physical instructor, she was fairly co-operative but untidy and seclusive. At first her responses seemed adequate to the restricted range of the conditions to which she was exposed. Later, she became tearful and unstable and said she wanted to go home. She appeared very unhappy but had no seizures during the first month.

On June 23, 1945 she was transferred to the open children's cottage. There she reverted to the previous behavior mentioned in the history. She wandered away from the cottage, destroyed her own belongings and those of others, removed articles of clothing, used obscene language and engaged in tantrums. She cried a great deal, was afraid of the dark, refused to go to bed unless an older child stayed with her until she went to sleep. She frequently complained that no one liked her and that she was being mistreated. On July 5, the patient was transferred to the closed children's infirmary ward where she would be more closely supervised, although her seizures were considerably less than they were prior to admission to the colony.

On August 15, 1945 it was necessary to take M. S. out of the children's infirmary and place her in a ward with defective patients somewhat older than she was, because she destroyed her clothing and abused the other children of her own age. She struck, hit and kicked them and removed their clothing.

However, M. S. attended the closed ward occupational therapy with the other children. She played with educational toys, looked at picture books and did simple handcraft. She seemed to enjoy occupational therapy and looked forward to the coming of the therapist every morning. During this closely-supervised period she made no attempt to tear her own clothes or the clothes of the other patients. She did not play with the other children, but she did not abuse them.

On the ward she continued to engage in destructive activities. She had frequent tantrums. The nurse's notes stated that she

pushed several feeble patients to the floor. It seemed impossible to reason with her.

On September 3, M. S. was transferred from the closed infirmary ward to the closed day ward for behavior problems. While in this building, she attended occupational therapy classes for pre-school children. There she became a part of a group of little children who were exposed to a longer period of supervised occupational therapy. She participated in play, music, handicraft and story-telling techniques. As in the closed ward, during her supervised play period she did not tease the other children nor was she destructive. She was distractible and needed considerable attention. She worked well with older people but had to learn to play with children of her own age.

The nurse's notes reported that following admission to the ward for behavior problems M. S. slapped some of the children and then ran away and hid. She apparently liked to be coaxed and babied and wanted her own way. However, the child gradually responded well to the combined efforts of the physicians, nurses and the occupational therapist. On February 4, 1946 she was transferred from the closed wards and returned to the open children's cottage, because of her improved behavior. From the pre-school occupational therapy group she was transferred to the colony school.

The occupational therapy department continued to supervise her and her recreational activities. Her behavior continued to improve and she was admitted to the Brownie troop of Girl Scouts. This indicated not only adjustment to the group by the patient but acceptance of the child by the group.

From February until June, M. S. attended school regularly. During the summer vacation she spends her mornings and a part of the afternoon in the occupational therapy and physical therapy departments. She is free to go about the grounds and gets along well at her cottage. She is learning to associate with other children of her own age and to enjoy their company.

This emotional borderline defective seven-year-old child was subject to deprivation and rejection. Environmental factors as well as poor familial background entered into the picture. Although she received the same medication she had at home, her seizures diminished almost immediately upon admission to the

colony. However, her behavior presented a more difficult problem. Her record indicates she had only one seizure a month for the first six months at the colony as contrasted to three per week prior to admission. She has had no seizures since November 1945. While her neurotic traits and unstable behavior presented difficulties at first, there has been a corresponding improvement in her conduct. In addition her intelligence quotient and achievement ability have improved proportionately.

Summary

1. This paper summarizes certain important aspects of the Craig Colony program in the treatment of epileptics.

2. Particular reference is made to the value of occupational therapy activities and adequately planned nursing procedures in accomplishing some of the aims of a psychotherapeutic program.

3. Three cases illustrative of the occupational therapy program are presented.

Craig Colony
Sonyea, N. Y.

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THE ORGANIZATION OF A HOSPITAL BAND

BY CLAUDE F. HUBLEY

On October 16, 1945, when I started at Marcy State Hospital, Marcy, N. Y., to organize a band, little did I realize the task ahead of me. It would be many months before any instruments or music could be procured. Letters to band instrument makers, brought very discouraging answers. The opinion of most firms was that it would be about two years before we could obtain enough instruments to make up a band. These manufacturers had been turning out the tools of war and were not yet in production on band instruments.

Well, if I could get no new instruments for the band, I determined to purchase some used ones. A trip to local music dealers and through pawn shops brought me to a startling realization. There were no band instruments to be bought at any price! New York dealers had sent purchasing agents up-state to buy up all musical instruments. They had actually cleaned out the dealers.

There was another serious problem. When were we going to get money to purchase instruments when they were available? It was actually seven months before the appropriation became available. As we were very desirous of getting the band started, I began inquiring among my musical acquaintances: "Have you any band instruments I can either borrow or buy?" One had a very ancient cornet for which I paid five dollars. A trip to the music store for a pair of drumsticks, a drum instruction book and a cornet instruction book gave me the material with which to start. Now I could start training cornet and drum players. Several months later a friend loaned me a small bass horn and another allowed me the use of a clarinet. I also made an arrangement with local music dealers. They were to give me first chance to purchase any used band instruments that came into their stores. This latter arrangement enabled me finally to get enough instruments to put on our first band concert in less than one year. If I had been obliged to wait for new instruments it might have taken three years. That delay would have been damaging to morale.

The next step was to find a suitable place to teach the players. A careful survey showed that all the desirable locations were in use.

The only suitable space available was in the basement of the assembly hall. There the bowling alleys occupied one-third of the floor space. The other two-thirds were seldom used except for storage. Permission was obtained to take over half of this storage space for band use. Later, it was partitioned into our present band and practice rooms.

The next problem was to find patients in good enough mental and physical condition to allow them to learn to play band instruments. They must be in fair physical condition, should have most of their front teeth, and must be mentally capable of learning music.

A visit to the supervisors of the various buildings followed. They assured me that some of their patients were "musically inclined." An interview disclosed the fact that none of these musically-inclined patients was suitable material for the band. For example, one aged man said that he had played bass horn for many years with a band. He had no teeth and, being over 70, was not physically strong enough to play bass horn now. Several other patients played the piano but their lack of teeth or poor physical condition eliminated them as band possibilities. I then decided to look through the wards myself to find suitable patients. Of course I learned then that most of the patients in fair physical and mental condition were working either in the laundry, the industrial building, or the occupational therapy department. Those left behind on the wards were of the poorest physical and mental types. Very few of these could be assigned to the band. The other departments were very reluctant to give up any of their better patients to the band. However, we have succeeded in using patients from both categories.

A rather gloomy outlook for the bandmaster; no money to buy instruments, no band instruments available and no patients with any previous musical experience! With the antique five-dollar cornet and a pair of drumsticks, I decided to make a start, however. The supervisor of G building offered the use of the visitors' room for teaching patients. Then I began the process of interviewing patients on the wards, selecting the best of them and giving a half-hour lesson to each. Most of these flunked. Many of them never succeeded in producing a musical sound. Others made

no progress and quit. Only occasionally would a patient be found with enough musical talent to justify continuing his instruction.

There were to be many disappointments in the future for the bandmaster. A ward charge informed me that one of the patients had had considerable band experience, playing the cornet. I wasted no time. In a few minutes the patient was playing beautifully on the cornet. My hopes rose to the skies! Here at last was a patient with musical talent and band experience, one who would be the solo cornetist of the band of the future, one who could help hold up the beginners. But my hopes were suddenly dashed to the ground: The patient informed me that most of the time his mental condition would not allow him to play the cornet. I have not been able to get him to play again!

A few days later a patient asked me if he could get in the band. He saw the drumsticks, picked them up and drummed very well with them. Next he picked up the cornet and played several bugle calls on it. I asked him if he had ever played the cornet. He said no, but he had played several years with a drum and bugle corps. Here was the material to make a fine cornet player and snare drummer, I thought. I gave him cornet lessons for about two weeks. He made excellent progress and began to play with some style. Again my hopes rose. Here at last was a patient with real musical ability. I would develop him into a fine cornet player. Several days later he informed me that he would no longer play on "that old cornet," but would play if I could get him a new instrument. As no new cornet was available, he refused to play any more. A year later when I received an almost new cornet I again induced him to resume his music lessons but his mental state had declined and his condition grew steadily worse until I was forced to drop him.

Since that time there have been many such disappointments. A patient to whom I gave clarinet lessons for over a year and who was playing well, left the hospital. A young man was rapidly becoming proficient on the saxophone but soon left the hospital. He was then capable of playing with a good dance band. (However, the thought that a patient going home may continue his musical career started at Marcy more than compensates for the many hours devoted to teaching him.) A man of 60 years, an accom-

plished mandolin player, had saxophone lessons for more than a year and was becoming a valuable player when a fatal illness overtook him.

So far, this is only the dark side of the story. I can assure you that the picture brightened soon, and that actually we had a happy time—all of us. Gradually, I developed enough players to form a small band of 12. They had been rehearsing together about 10 days when I heard that a large party for patients was to be held in the assembly hall. It occurred to me that this would be a grand opportunity to give our first concert and bring our band before an audience. Some people were saying, "We have had a bandmaster for about 10 months. When will we hear the band?"

The vital question was, Can this small group of 12 beginners put on a satisfactory performance?" None of them had ever played before an audience. None was sure of playing his parts correctly or of making the proper repeats. So far I had held the band together by singing loudly at all repeats and when some players went wrong. My better judgment told me that this could be a very risky venture. What if these players develop stage fright when the curtain went up—and what if they were unable to go through with it? We would be ridiculed and our morale would be injured greatly.

I put the question up to the players themselves. "Do you fellows feel that we can put on our first concert in two days?" They were unanimous. They said they could and would play a good concert. For two days, we rehearsed our program.

At last the big moment arrived. The band was all seated on the stage. The curtain opened and the announcer introduced the Marcy Band to the audience. Now everything was up to the band to make good or be the laughing stock of the hospital. The players did their best and we received many fine compliments on our first public performance.

This achievement gave the band's morale a tremendous boost. The players were ready to do big things now. Many concerts and outdoor parties followed and all were well played. Our most distinguished listener was Governor Thomas E. Dewey. We put on a concert for him and his party just two weeks after our first ap-

pearance. He said that he enjoyed hearing us and wished us success in enlarging the group and our repertoire.

By working very hard, our band has grown until it is twice as large as it was when the governor heard us last year. It now numbers 25 regular players. The regular instrumentation includes: four trumpets, three clarinets, three saxophones, two horns, two trombones, three baritones, three sousaphones, one marimbaphone, three drums and cymbals. In addition, 10 patients are receiving preliminary instruction in the following instruments: flute, piccolo, saxophone, trumpet and bass. From the personnel an orchestra and string group have also evolved.

Our repertoire has greatly increased. When the governor heard us we knew only six easy marches. Now we use a band book containing 50 pieces. It includes 36 of the finest and most difficult marches written. We play 10 of the best Sousa marches and several overtures.

Actually this band will become one of the best in this section, judged by any standard. More important is it that 35 patients have had individual and group intellectual stimulation, individual and group pleasurable emotional experiences and the socializing benefit of close co-operation in a joint enterprise.

Marcy State Hospital
Marcy, N. Y.

REPORT OF THE RESEARCH CONDUCTED AT THE NEW YORK STATE PSYCHIATRIC INSTITUTE DURING THE YEAR 1946*

BY NOLAN D. C. LEWIS, M. D.†

The methods adopted by men of science in their efforts to increase factual knowledge are far different than those advocated in the ancient days by Aristotle and even from those created in the time of Francis Bacon whose vision has been something of a guiding beam for centuries. The methods of science have been of exceedingly slow growth, and they are, as yet, by no means fully developed in the basic fields. In the field of the so-called "humanities," they are woefully inadequate.

One difficulty arises from the fact that in any attempt to solve human problems values have to be considered that cannot be brought under any physical law as yet discovered. Attempts to interpret some of these values in terms of objective facts are not very successful. The most abstruse problems of pure science seem to be relatively simple, but the human element seems to be incalculable.

At the institute efforts are directed primarily toward elucidating normal and particularly pathological human behavior. In order to accomplish anything worth while along these lines, every inviting or promising lead must be followed consistently to see what lies beyond. It is not only in keeping with our personal point of view but, as advocated everywhere in science, the area of greatest promise is that of the basic sciences, such as chemistry, pathology, genetics and other experimental disciplines. The research facilities of the institute are, therefore, devoted to a considerable degree to the exploration of basic fields. I should like to start this brief report with biochemistry.

Department of Biochemistry

The research activities of the department of biochemistry were directed, as in past years, mainly toward two major problems: the study of lipid chemistry and metabolism in relation to the nervous

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system and mental disease, and the study of glutamic acid metabolism in relation to its use as a therapeutic agent in mental disease. Several approaches to each of these problems were followed.

1. *Lipid Metabolism*

(a) *Choline Determination.* The problem of determining choline in brain lipids has become essentially that of finding satisfactory conditions for the hydrolysis of sphingomyelin. Findings obtained last year indicated that hydriodic acid might be a suitable agent for this purpose and this promising lead was studied in detail during the first half of the year. A preliminary report on the possible use of hydriodic acid as a hydrolytic agent for sphingomyelin was presented by Dr. Sperry and Mrs. Brand to the American Society of Biological Chemists. Although hydriodic acid does hydrolyze sphingomyelin rapidly, it appears also to destroy some of the choline. This was not recognized for a long time because, by an unfortunate chance, the loss of choline seems to be almost exactly balanced by an increase in the "blank" value. Although by the use of carefully standardized conditions and corrections based on control values it may still be possible to employ hydriodic acid in the determination of choline in brain lipids, it seemed best to turn to another hydrolytic agent, barium hydroxide, which has been used for this purpose by other workers, but which has certain disadvantages, particularly in the application to our micro method. During the past three months several of these difficulties were overcome and we are hopeful that a workable method may be devised with barium hydroxide as the hydrolytic agent.

(b) *Serum Cholesterol in Mental Disease.* This investigation was continued throughout the year. Data from a considerable number of new patients were added to the records and some progress was made in the study of the clinical records in relation to the serum cholesterol values.

(c) *Serum Phosphatides in Mental Disease.* During the year a study of the phosphatide concentration of the blood serum in mental disease was started. The investigation was stimulated by a monograph by Jokivartio who presents extensive evidence indicating that the phosphatide level is markedly reduced below normal in certain types of schizophrenia. Since no regular, consistent bio-

chemical abnormalities have been established in schizophrenia, this finding, if correct, is of considerable interest, and it seemed to merit further study.

(d) *Biochemical Changes Following Electric Shock Therapy.* This investigation, in collaboration with Dr. Horwitz, was continued during the first half of the year, and further support was obtained for the finding of a rapid withdrawal of water from the blood immediately following electric shock, as evidenced by a sharp rise in blood lipid concentration.

(e) *Studies of the Higher Fatty Aldehydes.* Dr. Waelsch and Dr. Ehrlich concluded their studies with deuterium as an indicator of the metabolic relationship between the higher fatty aldehydes and fatty acids. The results, which showed that these aldehydes are not involved in the over-all metabolism of the fatty acids, were published in the *Journal of Biological Chemistry.* In a further search for the metabolic function of the higher fatty aldehydes it was found that they are intermediates in the metabolism of long chain alcohols.

Evidence, obtained last year, invalidated the only method available for the quantitative determination of the higher fatty aldehydes. Dr. Waelsch and Dr. Ehrlich recently devised a new procedure which avoids the errors of the old method and makes possible reliable quantitative studies of these little-known constituents of the brain.

2. *Studies of the Metabolism and Therapeutic Use of Glutamic Acid*

(a) *Quantitative Study of Glutamic Acid.* A paper on the micro method for the determination of glutamic acid, described in previous reports, was published in the *Journal of Biological Chemistry.* This method was applied to the determination of glutamic acid and glutamine in the blood of healthy human subjects. The results, which will serve as a base line for comparison with findings in mentally-diseased patients, were presented to the American Society of Biological Chemists and a paper describing the findings was prepared for publication.

(b) *Antimetabolites for Glutamic Acid.* In continuation of this investigation, a large number of homologues of glutamic acid was synthesized and tested for their antimetabolic activity. It was found that the 1, 1 configuration of the sulfoxide derived from methionine is several times as active as other isomers, and there is some indication that this is a general relationship. Some of the findings were presented to the American Society of Biological Chemists, and published in two papers in the *Journal of Biological Chemistry.*

The glutamic acid antimetabolites are being tested for anticonvulsant activity by Dr. H. H. Merritt of Montefiore Hospital.

(c) *Glutamic Acid as a Therapeutic Agent in Mental Deficiency.* A preliminary report of the effect of glutamic acid in mental deficiency was published in the *Journal of Nervous and Mental Disease* by Drs. Albert, Hoch, and Waelsch. In seven of eight subjects, a significant and rapid increase in intelligence quotients, ranging up to 30 per cent, was observed following acid administration. When glutamic acid was replaced by placebos, the I. Q.'s receded to their original levels. These preliminary results are of manifest interest and importance, and, during the year, much effort was expended in an attempt to extend the investigation to a larger number of subjects. Arrangements were made, with the co-operation of the Board of Education of the City of New York, to test the effect of glutamic acid on 70 to 100 school children in the low I. Q. classes. The work was started during the fall but at the moment it is being delayed by organizational difficulties.

Tentative plans were outlined by Dr. Waelsch and Dr. Jervis of Letchworth Village for a similar study of the therapeutic effect of glutamic acid in selected patients of that institution.

(d) *Effect of Glutamic Acid on the State of Confusion Following Electric Shock Therapy.* This study is being continued.

(e) *The Toxicity of Glutamic Acid.* In collaboration with Dr. Gellhorn of the department of pharmacology of the College of Physicians and Surgeons, the pharmacological action of glutamic acid in experimental animals is being studied. The work on glutamic acid was supported by liberal grants from the Williams-Waterman Fund of the Research Corporation and by the Glutamic Acid Fund of Parke, Davis and Company.

3. *The Thyroid in Relation to Cholesterol Metabolism*

In addition to the foregoing two main problems, the investigation of the thyroid in relation to cholesterol metabolism was continued.

This was in collaboration with members of the department of anatomy of the College of Physicians and Surgeons. The findings on the effect of thiouracil in monkeys, described in previous reports, were published by Drs. Aranow, Engle and Sperry in *Endocrinology*. The studies are being continued in collaboration with Dr. Engle and Dr. Jailer, with particular reference to the effect of thyrotropic hormone in conjunction with thiouracil. The serum cholesterol did not exhibit a significant trend during treatment, but it may be that thiouracil has a labilizing effect on the central mechanism of this substance. Menstrual irregularity was more pronounced in the female monkeys during treatment. There were periods of amenorrhoea, and a treatment-resistant neutropenia developed in two animals.

Department of Internal Medicine

Studies have been carried out in the fields of metabolism, endocrinology, pharmacology and x-ray techniques, in the department of internal medicine.

1. *Quantitative Determination of Various Amino Acids in the Blood by Microbiological Methods*

Dr. Harris has been carrying out rather extensive studies of the microbiological methods for determining various amino acids in the blood. It is planned to apply these methods to a more detailed study of specific components involved in nitrogen metabolism in various neuropsychiatric conditions. The purpose of this study is to determine whether the metabolism of some particular amino acid or acids may be altered in some of the clinical conditions. Most of the previous studies have been devoted to the total nitrogen metabolism which is too crude a procedure.

2. *Glutamine Studies*

Studies regarding glutamine formation in the animal organism were continued during the past year. Since we had found that the level of glutamine in the blood is markedly depressed during insulin hypoglycemic shock therapy, plans were made to investigate the effect of insulin hypoglycemia on the glutamine level of various organs such as brain, liver and muscle. The studies thus far carried out in the rat, mouse and rabbit corroborate the findings of Hamilton in studies on the dog, namely, that the level of glutamine in the brain is about 10 times as high as that found in the blood.

It was also found, in separate analysis of the right and left cerebral hemispheres, that in some animals the amount of glutamine in one half of the brain was markedly different from that in the other half although the level of total amino acids was the same on both sides. This would seem to indicate that the enzymatic processes involved in either glutamine formation or destruction may be markedly different in two equivalent parts of the brain. The possible physiological significance of this finding may deserve further study.

3. *Steroid Hormone Studies*

Studies are in progress regarding chemical methods for the determination in urine of 17-ketosteroids, and chemical and biological methods in which adrenalectomized mice and rats are used for the determination of corticosteroids. The latter are the steroids which play a role in regulating carbohydrate, protein and electrolyte metabolism. It is planned to apply these methods to a study of the role of the androgens and adrenal cortical hormones in neuropsychiatric conditions.

4. *Glycine Therapy*

The effect of the administration to mental patients of large amounts of the amino acid, glycine, is under investigation in cooperation with Dr. Polatin and Dr. Horwitz.

5. *Ammonium Chloride Studies*

Studies regarding the effect in the rabbit of the intravenous administration of ammonium chloride on the electro-encephalogram and also on general physiologic reactions are being carried out in co-operation with Dr. Pacella.

Department of Bacteriology

The principal research project of the department of bacteriology for the past few years has been concerned with the experimental production of epilepsy in monkeys. In collaboration with Dr. Pacella and the department of experimental psychiatry, it has been shown that in Rhesus monkeys the application of alumina cream to one motor cortex produced a primary focus of EEG abnormality, characterized chiefly by delta activity, random spikes, and sharp formations. This abnormality appeared prior to the onset of Jacksonian attacks which could be elicited by physical stimulation. Subsequently, a secondary (mirror) focus of EEG abnormality developed on the opposite motor cortex, which was followed later by generalized convulsions.

A direct correlation was found between the degree of EEG abnormality and the convulsive threshold. Maximal EEG disturbance was usually associated with generalized convulsions. Minimal EEG abnormality was associated with Jacksonian attacks and was also present after the cessation of seizures.

It was of further interest to study the effect of ablation of the motor cortex in epileptic monkeys, and, in collaboration with Dr. Margaret Kennard, section of the corpus callosum.

Ablation of Area 4 resulted in eventual cessation of seizures and diminution of EEG abnormalities.

The limiting intravenous convulsive dosage of metrazol in monkeys exhibiting epileptic seizures, or in similarly prepared monkeys after ablation of the primary focus, or in a monkey in which alumina cream had been applied subcortically, was significantly lower than in control monkeys.

Fluorescence is one of the properties of certain substances, which involves some particular distribution of electronic energy, in which absorption of invisible ultraviolet radiation releases an

emission of visible light. The technic of fluorescent microscopy has been used successfully in the examination of sputum, urine, gastric contents, pus, spinal fluid, and various tissues. Fluorescence microscopy of nervous tissue, in collaboration with Dr. Edward Singer, is being investigated, and immunologic studies concerned with brain destruction are in progress.

Department of Medical Genetics

The research activities of the department of medical genetics proceeded along various concentric patterns, aided substantially by grants from outside sources. The main objective of these studies was to clarify the degree of interdependence of biological inheritance and physical environment in relation to both the ability and the inability to maintain a state of mental health and social adjustment in different life-situations. The principal investigative procedure used in this line of research was the "Twin Family Method" as developed by Dr. Kallmann.

The most extensive twin survey completed during the current year consisted of a consecutive series of 691 schizophrenic twin index families with a total of 5,776 individuals who had been kept under close observation for a period of 10 years. The results of this study indicated that the ability to respond to certain stimuli with a schizophrenic type of reaction depends on the presence of a single-recessive factor which must be inherited from both parents. Constitutional inability to resist the progression of a schizophrenic psychosis was assumed by Dr. Kallmann to be controlled by a multifactorial and probably nonspecific genetic mechanism. The specificity of the genetic predisposition to schizophrenia was demonstrated by the fact that no case of manic-depressive psychosis was found among the twin partners of schizophrenic twin index cases. It is in line with this observation that true cases of schizophrenia do not seem to occur in the sample of manic-depressive twin families, which is now being prepared for final statistical analysis.

Other completed twin studies dealt with the problem of *folie à deux,* which was shown to be in need of redefinition, and with the motivation of suicide which apparently occurs neither in mono-

zygotic nor in dizygotic twin pairs as a concordant trait even if the histories of the twin partners are very similar in regard to environmental background factors and psychotic manifestations. The inquiry into the socio-biological phenomena of suicide was extended in co-operation with the division of vital statistics of the New York State Department of Health, and the investigations of selected groups of epileptic, tuberculous and mentally defective families and of the morphological responses of schizophrenic patients to a combination of shock and fever treatment were continued in collaboration with various other departments and institutions.

In the twin study on aging, a representative sample of 459 non-institutionalized twin pairs over 60 years of age was collected with the aid of a newspaper and radio campaign, which was organized by the public relations staff of the State Department of Mental Hygiene. Of the present total of 1,450 aged twins collected from the various institutions and the general population of the State of New York, 934 twin index cases were still alive at the time of their last examination, 243 of them being 75 or older. Complete observation and analysis of this rather unusual twin sample will require considerable time, but it may be expected to yield valuable information not only regarding the psychiatric problems of aging and senility, but also regarding certain constitutional aspects of reproductivity, arteriosclerosis, cancer, diabetes and paralysis agitans.

Department of Neuropathology

In the department of neuropathology, the major activities of the year have been concentrated on the following topics:

1. Studies of experimental electric shock in monkeys. The first report on the effect of 12 to 18 electric shocks has been published in the October issue of the *Journal of Neuropathology and Experimental Neurology*. Another paper, dealing with the effect of protracted electric shock in monkeys up to as many as 100 electric shocks, is being prepared.

In the first group, slight structural changes of nerve cells and glia elements were noticed. More important, however, were slight changes of the vascular walls and occasional punctiform hemorrhages noticed in the gray or white matter. In evaluating the results of the experimental electric shock, the following factors were taken into consideration: (a) Intensity of the electric current. (b) Flow duration of the current. (c) Size of the electrodes. (d) Frequency of induction of the seizures. (e) Total number of induced convulsions. (f) Diet of animals and supervision of their physical condition. (g) Importance of serial studies. (h) Importance of quantitative evaluation of morphologic changes compared with control material.

2. Another important problem which is being investigated is the effect of amino acid deficient diets on the central nervous system. A preliminary report of these findings was presented at the last Down-State Interhospital Conference held at the Psychiatric Institute.

Two papers dealing with the ocular changes resulting from tryptophane deficient diets and valine deficient diets have been accepted for publication by the *Archives of Ophthalmology*.

Changes in the central nervous system have been found in animals deprived of valine. These changes consist in marked structural alteration of nerve cells, above all, swelling and vacuolization in the anterior horn of the spinal cords. These changes may account for some of the neurologic symptoms which follow valine deficient diets in rats. Marked degenerative changes have been found in the testes in particular in tryptophane deficient diets and changes of a slighter degree in the adrenals. The liver and kidney also show more pronounced structural pathology in tryptophane deficient diets. All these findings are being presently collected for conclusions and publication.

3. In humans, histopathologic changes in pernicious malaria have been studied and the results of the findings published in the July issue of the *Archives of Neurology and Psychiatry*. The presence of punctiform hemorrhages and the presence of malaria pigment distributed in large quantities in most of the blood vessels seem to be the outstanding features. Proliferation of vascular en-

dothelium and acute swelling and ischemic changes of nerve cells were also reported.

Although hyperthermia and toxicosis were considered responsible for some of the severest changes; it was felt that the mechanical action of the pigment and the resulting embolus contributed in the pathogenesis of the lesions.

4. Pathologic findings in schizophrenics are being studied with the purpose in mind of interpreting their significance. Such studies are approached from the angle that pathology found in dementia præcox may be the expression of: (a) organic complications in the course of schizophrenia, (b) that of a primary organic disease, and (c) that of a composite picture of interplay of soma and psyche namely in the direction that functional changes may ultimately lead to structural damage.

5. Pre-senile psychosis. Biopsies of two cases of pre-senile psychosis, clinically diagnosed as Pick's disease, have been studied; and reports were presented at a symposium on this subject at the New York Society of Clinical Psychiatry, on March 14, 1946. Particular emphasis was given to the possible correlation between some of the neuropathologic changes and the variation in respiratory enzymes of the cerebral tissue.

Department of Experimental Psychiatry

In the department of experimental psychiatry, investigations have been carried out in three different fields, as follows:

1. *Clinical Research Activities*

(a) The psychological testing of shock therapy patients included the use of the Minnesota Multiphasic Personal Inventory test and the Rorschach examination on patients before and after shock therapy. The project was completed this year, and a paper was presented by Drs. Pacella, Piotrowski and Lewis, before the American Psychiatric Association meeting in Chicago, July 1946. The Minnesota test was found to be of some value for determining whether the patient is likely to retain any improvement in his condition that has taken place as a result of treatment. It also readily reveals the increase in symptomatology and in anxiety which

psychoneurotic patients and unimproved schizophrenics show subsequent to therapy. The Rorschach test was of considerable prognostic aid.

(b) A project dealing with convulsive seizures following sudden cessation of barbiturate medication and alcohol was completed during 1946, and a final paper is in preparation. It was found that these patients do not necessarily have convulsive patterns in their electro-encephalograms, but that they do reveal temporary toxic cerebral effects in the electro-encephalographic patterns.

2. *Animal Experimentation*

(a) The important problem of the study of experimental epilepsy in monkeys is being actively conducted by Dr. Pacella in collaboration with the department of bacteriology. Additional neurophysiological and electro-encephalographic studies have been carried out and a paper, "Electro-encephalographic Studies of Induced and Excised Epileptogenic Foci in Monkeys," has been completed and accepted for publication in the *Archives of Neurology and Psychiatry*. It was observed, in these animals, that a primary epileptic focus can discharge abnormal electro-encephalographic waves which spread in particular to the surrounding regions of the homolateral side and also to the contralateral homologous area. In severely reacting monkeys, the entire brain shows abnormal electro-encephalographic potentials to such an extent that the original focal site may be masked. Surgical excision of this focus stopped clinical seizures and also resulted in at least temporary diminution of electro-encephalographic abnormality.

(b) Attempts are under way to record electric potentials directly from the exposed brain in order to define accurately the borders of the epileptic focus in experimental monkeys.

(c) Experimental poliomyelitis in the monkey and the guinea pig was studied electro-encephalographically by Dr. Pacella in collaboration with Drs. N. and L. Kopeloff of the department of bacteriology and with Dr. Jungeblut of Columbia University. The purpose of the investigation was to determine whether brain wave changes could be detected before the clinical features of paralysis were evident. It was found that there was no significant electro-encephalographic abnormality during the incubation period or pre-

paralytic stage in monkeys or guinea pigs infected with poliomyelitis virus. These observations were combined with electro-encephalographic findings obtained in a series of human, poliomyelitic, convalescent patients who showed residual paralyses; and a manuscript was prepared which has been accepted for publication by the *Archives of Neurology and Psychiatry.*

3. *Electro-encephalographic Investigations*

(a) Routine electro-encephalographic tracings were continued on all patients admitted to the Psychiatric Institute. In addition the department has continued to extend its facilities to a number of state hospitals which do not as yet have electro-encephalography machines.

(b) Electro-encephalograms of patients receiving convulsive therapy are still under observation. Tracings are recorded from all patients before and after treatment. At the present time a manuscript is in preparation dealing with the effects of induced convulsions upon the clinical status of patients who show various types of abnormal electro-encephalographic tracings before shock treatment is administered.

(c) Electro-encephalographic investigations of patients suffering with dysinsulinism, spontaneous attacks of hypoglycemia and diabetes mellitus are being carried out in collaboration with Dr. Fabrykant of the New York Post-Graduate Medical School and Hospital. Many of these records show cerebral dysrhythmias and a preliminary report of the observations is almost completed.

(d) The study of electro-encephalograms in patients with scleroderma is still being conducted. Abnormal electro-encephalograms have been found in over 70 per cent of the cases.

Training facilities in the technic of recording electro-encephalograms and in electro-encephalographic interpretation have been made available to personnel from a number of the state hospitals.

Department of Psychology

In the department of psychology, investigation of the psychological changes during and after electric convulsive therapy has been continued on an expanded scale. Previous findings regarding the temporary nature of memory impairment and of the relative

invulnerability of recognition as a memory factor have been confirmed. After electric convulsive therapy patients usually deny ever having seen the psychological test material before, even though it had been thoroughly learned and was quite familiar. This loss of a sense of familiarity is now the subject of special investigation.

Following treatment patients frequently report a splitting of emotion from memory. They say they remember the things that troubled them but the emotion is no longer a part of the memory. To investigate this point more closely, the association test procedure of Jung was modified to include words from the patient's own history which might be expected to be emotionally charged or to be complex-indicators. Before treatment two-thirds of the key words of this sort were reacted to in an emotional fashion. After treatment only one-third were so reacted to.

Sorting tests have been used by psychologists for some years past as indicators of the ability to generalize or to think abstractly. Following electric convulsive therapy, manic and depressive patients yield better scores on the sorting tests, while the scores of the dementia præcox patients are unchanged.

During the course of treatment, most patients show some loss in intelligence as indicated by standard tests. After the treatment is completed, the patient very rapidly returns to his pre-treatment level of performance. Indeed, some patients seem to increase their intelligence scores after treatment, an increase which is probably due to generally increased mental functioning after the psychotic symptoms disappear.

If one observes a fixed pinpoint of light in an otherwise totally dark room, this fixed point seems to move in the darkness. It has been claimed that patients receiving electric convulsive therapy perceive more motion than do normal individuals. This point is being investigated. So far, the limited number of patients studied has failed to show an increased amount of apparent movement.

In connection with the teaching and training of clinical psychologists, a number of tests, experiments and projective technics have been standardized and formalized. It is hoped that in a few years material will be at hand to provide a psychological test manual

which will be of service in the examination of patients in any mental hospital.

The department of psychology has been actively interested in helping to establish a research unit of biopsychology at Rockland State Hospital. Dr. Henry Nissen, who has accepted the appointment as director of this unit, was on temporary appointment in the psychology department in 1944 and is now a member of the department assigned to Rockland State Hospital. This new unit should greatly increase the progress of research in the State Department of Mental Hygiene. The institute staff is very pleased that it has been able to help in the start of this project.

Department of Clinical Psychiatry

In clinical psychiatry during the past year, emphasis has been placed upon therapy in connection with the management of primary behavior disorders. For this reason children with both the neurotic type and delinquent type of primary behavior disorder have been hospitalized for relatively long periods; and intensive therapeutic programs have been conducted with the in-patient group. These therapeutic methods may take the form either of a superficial approach or of a modified child analysis approach with the use of interpretative therapy. Supplementing the physician-patient relationship is the intensive program of routine activities and special activities in which the children participate during the day. This involves attendance at the regular public school situated in the hospital, athletic and other socializing activities and occupational therapy.

A number of schizophrenic children were studied in connection with a project which has just been initiated for the study of symptomatology from a psychodynamic point of view. This has been undertaken by Dr. Margaret Mahler, with the collaboration of Dr. Bernard Pacella.

A long-term investigation of follow-up studies of all children who have been admitted to the Psychiatric Institute since 1929 has been initiated by Dr. Pacella with the collaboration of Dr. Mahler and Dr. Goodman in an attempt to evaluate the present level of adjustment of individuals who were formerly problem children. Such a project will shed light upon the effects of earlier psycho-

therapy upon later adjustment-abilities of these patients and might also indicate a type of early personality structure which would predispose to any subsequent psychiatric conditions which these children may have developed in adult life.

Studies of tic manifestations in children are being conducted by Dr. Mahler who has now undertaken to incorporate her material in monograph form. This is the most comprehensive study of tics since the early days of the French authors who gave us our best temporary orientation in the subject.

Electro-encephalographic observations are being continued on all children admitted to the service with a view to determining the incidence of abnormal electro-encephalograms in the various primary behavior disorders and also with a view to determining the effects of various forms of psychiatric treatment upon these brain waves.

Three children's conferences are held weekly, conducted respectively by Dr. Mahler, Dr. David Levy, and Dr. Pacella.

The out-patient department continues to function on an active basis, although the case load has necessarily been limited by lack of sufficient trained physicians to handle children's problems.

At present a large number of children, who are in special classes in the New York school system, are being treated with glutamic acid. These children are suffering from a primary or secondary form of mental deficiency. This project has only been in existence a short time, therefore no conclusions can be drawn at present on the efficacy of glutamic acid. A new project was started for use of glutamic acid as a shock treatment. Patients are receiving glutamic acid intravenously in doses which produce vasomotor reactions. At present no conclusions can be drawn as to the effect of the glutamic acid shock in schizophrenia.

Sodium amytal was used intravenously for diagnostic purposes and in connection with psychotherapy. It was found that narcoanalysis is rather effective in acute anxiety states, and in certain psychosomatic conditions; is less effective in the obsessive-compulsive states, and in the psychoses.

Research was started on the production of psychotic reactions with mescaline. It is intended to try to influence these experi-

mentally-produced psychotic states—which are very similar clinically to schizophrenia—with psychotherapy, narco-analysis and shock treatment.

Combined electric shock and fever therapy in the treatment of schizophrenia has been carried out on four patients. This work is a continuation of the project begun with the use of combined insulin and fever treatment. A report of the work was read at the American Congress for Physical Medicine, September 6, 1946 (to be published). Combined insulin and electric shock therapy has been done in collaboration with Dr. Kalinowsky. Material is being gathered for a report on this soon.

In collaboration with Dr. Linn, we are investigating the residual effects on patients who, seven years ago, manifested vertebral fractures as a consequence of insulin and metrazol convulsions occurring at that time. We are interested in determining whether there are any residual neurologic or orthopedic complications. This work is still in progress and is functioning slowly because of the difficulty of making contact with patients who were resident here so long ago.

The investigations of a new drug manufactured by the Hoffmann-La Roche Company, called NU-903, have been completed. This drug is a pyridine derivative and not a barbiturate. It is a sedative hypnotic; and, after an investigation in 100 psychiatric patients, we have come to the conclusion that it is a quick-acting drug of short duration, effective as a hypnotic in mild cases of insomnia and equally effective as a sedative in mild, or even moderately severe cases of tension and anxiety. It is not habit-forming, has no definite side-effects and produces no change in the blood picture.

In collaboration with Dr. Spotnitz, we have completed our observations on the combination of ambulatory insulin with electric shock therapy. We have found that although electric shock therapy produces rapid favorable effects there is also a rapid relapse. The insulin, on the other hand, produces slowly accumulating favorable effects. We have combined the two by giving six electric convulsions, followed by ambulatory insulin, and have found that the rapid improvement produced by the electric shock is sustained with the ambulatory insulin in schizophrenic conditions.

Social Service Department

Research is being carried on in the social service department by individual studies and in collaboration with other departmental projects.

Drawn from institute case material, eight theses by students, in partial fulfillment of their requirements for graduation from the New York School of Social Work, have been completed. These subjects for study are usually selected by students as a result of a special interest, stimulated by some aspect of their experience in case work while at the institute. Subject titles and authors are as follows: (1) "A study of some Roman Catholic religious and cultural factors affecting human behavior with an analysis of incidence and treatment of these in 10 selected cases under care of New York State Psychiatric Institute and Hospital," Gloria Vetter. (2) "A study of dependency factors in 15 army wives admitted to the New York State Psychiatric Institute and Hospital," Dorothy Castiglione. (3) "A study of sibling rivalry in seven children with special focus on the family inter-relationships," Herta Mayer. (4) "A case work study of double contacts in a psychiatric setting," Esther Bromsen. (5) "The discharged mental patient," Edna Gersh. (6) "A study of guilt feelings in eight mothers of patients at Psychiatric Institute," Annabel DeKoven. (7) "The evaluation and treatment of mothers of mentally-ill children," Joan Guilmartin. (8) "A follow-up study of adolescents hospitalized for schizophrenia at New York State Psychiatric Institute and Hospital," Almena Parker.

Studies in collaboration with other psychiatric services to estimate the social adjustment and health conditions of former patients in their family situations are in process in both adult and children's cases.

Twenty-nine former child-patients have been seen singly and with their family members. In a number of instances, their homes have been visited. This study, carried out under the guidance of Dr. B. L. Pacella, chief of the children's service, is planned to appraise the current conditions of those children hospitalized since 1930 to the most recent discharges. These former child-patients are, in many instances, grown to adulthood. The original diag-

noses, usually primary behavior problems, conduct, habit, or neurotic types, are being re-evaluated by the physician who, likewise, interviews the patients. It is interesting to note to date, that the decrease of symptoms, or the progressive development of the maladjustments, in the former child-patients interviewed, seems to relate directly and proportionately to the kind of relationship and understanding reflected by the parents or family members. In most instances which are illustrative of improvement, social service workers have spent intensive times with the parents or families of the children whose attitudes or personal maladjustments and living conditions, have become modified and improved. Many of the children, now adults, have, likewise, been clearer and better able to evaluate their mental and emotional conflicts or blocks, indicating the insight gained from early psychiatric treatment.

A study of the conditions of 40 adult patients, first treated by convulsive shock therapies, who suffered vertebral fractures, is nearing completion under the direction of Dr. Phillip Polatin, chief of the female service. Contacts with patients and their relatives have been made in all instances possible, by physician and social worker in this study. Many of these patients have entered other New York State hospitals; and reports gathered of their mental and vertebral conditions, have been received through the generous responses of the directors and physicians of these institutions who have made completion of this study possible. It is gratifying to note from social service evaluation, that the social adjustments of patients living in the community have stabilized and improved in most instances, some of these patients having also experienced subsequent state hospitalization. In most of these cases, the patient's formerly tense familial situation has altered either by improvement in family relationships with the patient's improvement, or by his physical separation from his family problem.

For a number of years, social service has continued to check through one-contact follow-up interviews, the current adjustment of former adult patients, treated by insulin, electric convulsive therapy, or metrazol. During the past year, 19 males and 21 females have been interviewed for this purpose. In most instances, the patient responds willingly to this single contact. In many, fur-

ther consultative service is desired by the patient for social planning. A few have relinquished all former symptomatology and can be evaluated as making an adequate, some a highly successful, adjustment. In other instances, these patients have learned to live with their symptoms which are definitely reduced from the acute or episodic phase. In a few instances, the patient's total adjustment is still a poor one. Generally, the social betterment and improved use by a patient of his personality assets have developed in direct proportion to the familial improvement obtained, and follow a period of supportive contact by social service workers aiming toward community readjustment after the patient's discharge.

Without this kind of research on former patients, little can be learned or evaluated concerning the results of their hospital and social treatment gains. The time involved in locating patients who have changed their addresses, and in interviewing them or their families, obviates the possibility of carrying through such a study upon the large-scale program desirable, without the addition of a social service research staff. New projects covering 100 or more cases, are being constantly planned in psychiatric research where trained social workers for research are increasingly required.

Publications from the department during the year 1945-46 have included two collaborative studies, namely: (1) "Case work with schizophrenic patients treated with shock therapies," by Rowena Ryerson, and "Shock therapy and schizophrenia," by Phillip Polatin, M. D.; (2) "Case work with psychiatric patients treated with shock therapy," by Rowena Ryerson, and "Shock therapy in psychiatry," by Phillip Polatin, M. D.; and (3) "Psychiatric social case work with children," by Leona M. Hambrecht, as a chapter for the symposium, *Modern Trends in Child Psychiatry,* edited by Nolan D. C. Lewis, M. D., and Bernard L. Pacella, M. D.

Occupational Therapy Department

During the year, an average of 135 patients a month has attended occupational therapy in the shops. Activities such as dances, parties, moving pictures, have been attended by all patients.

Progress has been made in the use of art media; and there has been increased interest by the doctors in the patients' art production, the material having been used in psychotherapy and for research purposes in a greater number of cases than in previous years. Active research on the use of the art productions of patients as expressions of mental conflict and as attempts at self-cure, constitutes an important project.

Conclusion

Although this report has had to be drastically curtailed to bring it within the limits of our present time and space, it is sufficiently comprehensive to indicate the consistent work and splendid cooperation of the individual members of the staff, to all of whom I wish to express my gratitude for making such a scientific report possible.

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"CRIME AND PUNISHMENT"

Why Punishment Fails to Prevent Crime

BY EDMUND BERGLER, M. D.

Every time a psychiatric criminologist states that punishment, based in part on the deterrence-theory, is a poor preventive method, he is immediately confronted with the angry question: Do you propose to leave the criminal unpunished?

Therefore, a clarification of that question is necessary at the beginning. Society has the right to protect, and is justified in protecting, the law-abiding citizen. Every society must protect itself against individuals who do not accept the rules of the community. No one denies that the criminal must be prevented from repeating his criminal deed. No one suggests that the criminal be left to run around, free and unmolested.

A famous incident in the French Chamber of Deputies is paradigmatic for the emotional upheaval surrounding this touchy problem. A deputy delivered a speech advocating abolition of the death penalty; whereupon another deputy exclaimed indignantly: "Now let the gentlemen assassins enter!" Applied to our problem; nobody invites the "gentlemen assassins."

The scientific investigation of the problem embedded in the question as to why legal punishment does not have the deterring effects for which the law-maker hopes, has nothing whatever to do with the idea of abolishing the legal procedure. The present approach is purely scientific; the question is simply: Why does the deterrence-theory give such poor results in criminal practice?

And poor results they are. From time immemorial criminals have been punished, and no student of history can contend that the punishments meted out have been too lenient. Still, people go on committing crimes, the element of deterrence is not highly impressive for the potential criminal.

The idea of deterrence is, of course, not the only reason for legal punishment. The triad, punishment—deterrence—rehabilitation, is constantly adduced by legal minds. Expressed or unexpressed, however, the element of deterrence is the primary hope and inner self-justification of judicial authority.

It is acknowledged today by legal theoreticians that deterrence *per se* is not the reason for the execution of the law. To quote Jerome Hall in the *Columbia Law Review*: "It is fallacious and unreal to deal with 'justice,' 'deterrence,' and 'rehabilitation' as mutually exclusive objectives of the criminal law of advanced systems; but if distinctions are made for purposes of analysis, then justice is plainly the paramount objective. Deterrence, alone, is barbarism—it would punish the insane in complete disregard of their being grievously ill—as Bramwell admitted ('I am not aware of any justice in this matter ultra expediency'). Treatment designed solely to reform is also unjust if the innocent are not excluded, if it frees those who have committed major crimes or if it incarcerates for long periods those who have repeatedly committed only petty transgressions. It also involves the untenable assumption that adequate empirical knowledge is available to rehabilitate or, even, to recognize with assurance those who can and those who cannot be reformed.'"[1]

Our problem—the practical failure of the deterrence-idea—is not concerned with explanations of the rather complex terms of justice, its alleged connections with vengeance and other emotional ingredients. We shall concentrate exclusively on the question: *Why does the mechanism of deterrence not work? The thesis is advanced that unconscious elements in the criminal's psyche prevent the results hoped for. The criminal wants unconsciously to be punished; hence threat of punishment is not a deterrent but rather—paradoxically—an allurement.* I stress specifically the *unconscious* connotation: Nobody doubts that the criminal wants *consciously* to avoid punishment.

To prove the present thesis, one must answer the question: Why are crimes committed in the first place?

There is no denying that social *and* psychologic reasons are intermingled in the phenomenon of crime. No reasonable person denies sociologic factors. The problem is, however, that of what degree of priority one may ascribe to these factors. In some cases the social factor in criminal actions is either an excuse, or, more often, a rationalization for hidden unconscious motives, or is the hitching-post for the repetition of undigested injustices, real or fantasied, in the childhood situation—afterward shifted upon so-

ciety or the social order in general. The more superficial rationalizations are often generally accepted *because* they seem obvious. The difficulty in comprehending unconscious factors is not only based on the fact that they are beyond the level of consciousness, and therefore not known to the individual and to the casual observer. To top the difficulty, another factor obscures the picture: Unconscious factors—since incomprehensible to consciousness—must be made palatable to common sense; hence they are secondarily wrapped up as "rationalizations." Rationalizations and true unconscious reasons are, therefore, not at all identical; quite the contrary—no more than camouflage and the object to be hidden by camouflage, are identical.

Why do people commit crimes? If one surveys the enormous literature accumulated on that subject, one must admit that with exception of a somewhat changed and more scientific-sounding terminology, little more is known than the Bible had to offer. J. B. S. Haldane, Fullerian professor of physiology, Royal Institution, London, has said:

"Why do people commit crimes? This question had been asked, and answered, ever since we have any record of human thoughts. In the Bible we find answers of various kinds. Evil acts are sometimes put down to supernatural interventions, as when the serpent tempted Eve, and the Lord hardened Pharaoh's heart. Sometimes they are ascribed to the influence of another man, as when Jeroboam, the son of Nebat, made Israel to sin. In other passages the *source of evil is placed quite emphatically within us.* According to Jeremiah, 'The heart is deceitful above all things, and desperately wicked: Who can know it?' And Jesus said, 'Out of the heart proceed evil thoughts, murder, adulteries, fornications, thefts, things which defile man.' "[2]

The question is, of course, what is "the heart." It is obvious that it cannot be taken literally. Haldane satirizes the Biblical statement by pointing out gleefully that "the heart has very little to do with moral behavior; heart disease does not lead to evil conduct." We know also that the term "heart" is used allegorically as the seat of feelings. In this sense, the word "heart" means something similar to what we call in modern terminology—*the*

unconscious. And modern criminology has placed the motivations for crime exactly at that—anatomically indefinable—point.

Criminologic science went through many phases until it arrived at that crucial point of departure. Numerous factors were adduced—social, economic, biologic, classificatory psychiatric ones were brought forward. All these attempts ended in failure or incompleteness; the riddle of crime remained unsolved.

The situation changed with the advent of modern psychiatry based on Freud's discovery of the dynamic force of the unconscious. Freud proved that the old philosophical conception of the unconscious is more than a mystical toying with nebulous words. The unconscious became a clinically provable, dynamically effective, and therapeutically available fact in the *therapy of neuroses*.

At that point the tragedy of errors started all over again. Everything Freud proved for neurosis, was schematically applied to "criminosis," to use an excellent term coined by Foxe. Neurosis and criminosis were identified. That identification resulted in confusion.

One of the earliest and decisive discoveries of Freud pertained to the Oedipus complex. It denotes the fact that the child's sexuality does not start—as previously assumed—after puberty, but much earlier. From the age of two and one-half to five, the child goes through a period in which it attaches the *precursors* of its sexual wishes to the parent of the opposite sex, and its aggressive feelings to the parent of the same sex. Applied to the boy: He wants to take his father's place in relation to the mother, and eliminate his competitor, the father. Normally, that transitory phase is passed without danger, the sexual wishes directed toward the mother are de-sexualized, the aggressive wishes directed toward the father, shifted. In the neurotic state, these wishes are unconsciously retained and produce in later life the basis for neurotic symptoms and signs in hysteria and obsessional (compulsive) neuroses.

It took the scientific world nearly half a century to digest the Oedipus complex. Every science is far ahead of that part which has been accepted by conservative contemporaries. The situation is understandable if one takes into account the incubation of new ideas. The same thing happened with Freud's Oedipus complex.

At the time the latter was accepted—at least partially—psychoanalytic psychiatry was already occupied with the pre-stage of the Oedipus complex, the so-called pre-Oedipal phase, the problem of aggression and the subdivisions of the unconscious into different "provinces."*

The pre-Oedipal phase was sketched by Freud in the last decade of his life. It involves the early relationship of the child to the mother, and comprises, therefore, a dual situation, in contradistinction to the Oedipal phase which is a triangular one—child, mother, father. The mother of the pre-Oedipal phase is—although objectively identical with the Oedipal mother—*psychologically* a completely different personality. The mother of the pre-Oedipal times is not conceived by the child as kind, giving and helping. This contrasts most precisely with the facts, since the baby would—without his mother's care—die of hunger and exposure. True enough, the trouble with these facts is that they are viewed from the standpoint of the intelligent adult. The very young child's conceptions of reality are completely different from the adult's—as reconstructed from later neurotic reactions. The child lives for a considerable time in magic conceptions, considering himself omnipotent. He knows only one yardstick, his own overinflated ego. His misconception of reality is fostered by the conduct of the mother, who automatically attempts to fulfill all his wishes concerning nourishment, sleep and attention. The child misconceives casuality and sees in these wish-fulfillments, not the result of kindness and love of the mother, but simply the result of his own megalomania.

If one ponders for a moment upon this strange outlook on life, one can well conceive of a psychology which neglects every appreciation for good received, and considers every refusal, necessary as it may be, a "terrible injustice."

The dual, pre-Oedipal relationship of the child shifts gradually into the triangular Oedipal phase. The reasons are two-fold. First, the child learns very gradually to acknowledge grudgingly that it is, after all, dependent on the mother's kindness. The anger and

*The Freudian concept of the unconscious includes three divisions: the "*Id*," the reservoir of unconscious repressed wishes, the "*Super-ego*," the unconscious part of conscience, and the "*Unconscious Ego*," a mediator between both.

fury, springing from the not fully-relinquished idea of omnipotence, continue and lead to a painful conflict called "ambivalence." The latter term denotes the simultaneous presence of positive and negative feelings toward the same person. That conflict is resolved in the male child by splitting it off: Hatred, originally directed at the mother, is shifted to the father, love remaining with the mother. So the child enters the triangular Oedipal phase.

The second factor leading in the same direction, is the fact that the father is simply there and must be taken cognizance of. Only a baby can ignore him.

The primary difficulty with criminotics lies in the fact that *they act unconsciously under the influence of a pre-Oedipal, and not of an Oedipal conflict.*

I conceive of the criminotic as the *most passive person in this world,* helpless as a baby in his motorically-inexpressible fury. The giant of a mother is not even impressed with the fact that the helpless child wants to take revenge for alleged injustices. *The motor act in criminosis is based on the inner feeling of being incapable of making the mother even feel that the child seeks revenge on her. The situation is that of a dwarf trying to annoy a giant who superciliously refuses to see these attempts.* There is a direct relationship between the "herostratic" tendency in criminosis and the feeling of helplessness in making revenge evident. *Because of his inner feeling of being a dwarf, the criminotic uses, so to speak, dynamite.* Of that the giant must take cognizance. True, the "revenge" harms the avenger. He may be legally executed. However, the primary inner aim of forcing the giant to acknowledge the dwarf's fury, is "fulfilled."

Every criminal action has something "herostratic" about it. Herostrates was the individual who, in 356 B. C., burned the famous Temple of Artemis in Ephesus in order to become "renowned." Our "herostratic" criminals unconsciously perform similar deeds with another purpose: unconsciously to force the mother of their earliest childhood to acknowledge that they are at least capable of taking revenge upon her. The deepest and dynamically most effective core in the unconscious conflict of the criminotic is the compensatory, concealed helplessness, expressed originally toward the mother and only later shifted toward society.

The conception of crime outlined here differs specifically from the usual schematic applications of analytic knowledge, gained from the therapy of neuroses. The usual misconception is that an Oedipus complex is "discovered" in criminals. The proud but naïve authors of certain treatises flatter themselves on being very "modern," and assume at the same time that they "discovered" the "reason" for crimes. Unfortunately for these "pseudo-discoverers," the Oedipus complex can be found in every human being. Unfortunately for these pseudo-discoverers, not everybody burdened with this complex commits crimes.

Schematic application of neurosis to criminosis leads to another fallacy, too. That fallacy consists of the fact that the finding of unconscious motivations in a specific criminotic is used for explanation of the motor act. *Psychologic motivations* and *Motor act,* i. e., the execution of the specific crime, are two distinct and different things. Hence the confusion is further increased.

In the present writer's opinion,[3] the major confusion in criminal psychopathology is the failure to differentiate between a *variable* and a *constant* factor in every criminal action. The variable factor is made up of the *psychologic contents,* and is multitudinous in form, differing in every case. The variety of motives for a crime is as great as the variety of unconscious motives in general. The constant factor in crime is the unknown "X" which explains the *motor act* of executing the criminal move itself. This constant and pathognomonic factor I have proposed to call the "mechanism of criminosis." These two factors must be determined in every criminal action.

The differential diagnosis between these two factors is accomplished by keeping in mind the following: The variable factor explains the unconscious contents of a criminal action. To explain these, we must use all of the knowledge of unconscious mechanisms which Freud has discovered and so successfully applied to the explanation of human conduct in general—unconscious wishes, defense mechanisms, projections, identifications, atonement of unconscious guilt feelings, etc. The constant factor, the mechanism of criminosis, refers, not to the variable psychologic contents of a specific crime, but to the motor act executing the results of the variable factor. I repeat, the real riddle in crime is the motor act.

It borrows from the inexhaustible source of aggression, using it as the most primitive of human trends without revealing whether that aggression is primary or secondary (pseudo-aggression, that is, aggression used as an unconscious defense mechanism).

What happens if these two decisive factors are not differentiated? The answer is simple, confusion is rampant. That confusion is based mainly on naïveté, sometimes on malice. As an example of the latter, the *cause célèbre* of Halsmann can be cited. The reactionary medical faculty of the University of Innsbruck in pre-Hitler Austria was asked by the court to express its opinion of the reason why a young Latvian Jew killed his father, a crime which the defendant denied and which could only be "proved" by more than doubtful circumstantial evidence. The Nazi-infested faculty decided that Halsmann had an Oedipus complex which was "operative." Freud objected to this biased nonsense, pointing out the universality of the Oedipus complex. Said he: "Even if the conflict between father and son could be proved, one must say that there is a great distance between this conflict and the causative factors of such a crime." Freud illustrated his point by a joke: A man was sentenced for robbery on the ground of circumstantial evidence, having been arrested near the robbed apartment with a skeleton key in his pocket. Asked if he had anything to add when his sentence was passed, he replied that he wanted to be sentenced also for adultery, having that "key," too, in his pocket. The "great" distance mentioned by Freud is exactly the distance between present ignorance and the finding of the "specific factor" in crime.

Obviously the eradication of a misconception is a considerable job, since it involves overcoming the human reluctance to think, or the preference to think along lines of prefabricated patterns. Examples of the naïve variety of the same fallacy are to be found in numerous scientific journals and books. The basis is regularly the same: confusion between neurosis and criminosis. This went so far that a serious and well-known criminologist like Ben Karpman issued the warning: ". . . the psychoanalytic approach has as yet failed to contribute significantly to the solution of the problem because it gratuitously went on the assumption that the same mechanisms operated in criminals as in neurotics . . . The great

majority of the professional and habitual criminals must be approached by a method different from that used for neurotics.'"[5]

The objection is fully justified, and, today, theroretically more or less acknowledged. This does not prevent, of course, the constant repetition of the same fallacy by enthusiastic scholars who are happy to "discover," for instance, an Oedipus complex in criminals, and naïvely believe that they have explained the phenomenon of crime. They are disturbed neither by the fact that every human being goes through the Oedipal phase nor by the fact that the criminal, instead of being content with a good-sized neurosis, perpetrates a deed which lands him in a prison cell or death chamber.

Our next question is: What about the *aggression* executed in the criminal deed? Is it *real or defensive,* representing compensatory inner passivity?

The fact that biologically the human being has aggression at his disposal is not questioned today in psychopathology. The differences of opinion start, however, when the vicissitudes of that drive are taken into consideration. There are *three types of aggression*: *normal, neurotic and criminotic.* Let us first differentiate between normal and neurotic aggression.[6]

Normal and Neurotic Aggression

Psychiatric experience proves that there is but a quantitative distinction between a normal and a neurotic person. For practical purposes we have to draw a dividing line; theoretically, people of both types struggle with the same inner problems. Their solutions are different; their unconscious technics preceding the unraveling of the Gordian knot are also different. Basically, normal men and women are not the opposites of neurotic ones. In other words, a "not too neurotic person" can be euphemistically called normal. Everyone has neurotic tendencies, but not in everyone are they increased to such a degree that a neurosis results. It is a problem of quantity, not quality, although there is a point where "quantity changes into quality" (Hegel).

The decisive difference between a normal and a neurotic person is that the former has overcome to a greater degree his infantile

conflicts and is capable of having a relatively more objective outlook on reality, whereas the latter misuses reality for the unconscious repetition of his infantile conflicts.

Any neurotic can be compared to a person carrying around one phonograph record constantly, and continually on the lookout for a phonograph on which to play his only tune. In this simile the one and only record represents the basic unconscious neurotic tendency; the phonograph stands for the other person with whom the neurotic pattern can be repeated. Expressed differently, Freudian psychoanalysis has proved in 50 years of clinical experience that certain unconscious behavior patterns acquired in early childhood become petrified, and under the pressure of the "unconscious repetition compulsion" (Freud) are repeated throughout the remainder of life with eternal monotony—and completely without conscious awareness of that repetition. Thus, the unconscious "repetition machine" reels off the unconscious behavior pattern.

Neurotic persons are constantly in conflict with their environments. They are fighting their unconscious battles on two fronts: inside, as visible in their symptoms, signs, and personality difficulties; and, outside, in their quarrels, obstinacy, provocativeness. Hence the necessity arises for use of a yardstick to distinguish whether specific conflicts with the outer world are normal or neurotic. The differentiation is even more necessary, since a "normal" person can have, in a specific instance, a "neurotic" conflict, and a neurotic person a "normal" conflict.

The following tabulation makes a quick distinction possible:

Normal Aggression	*Neurotic Aggression ("Pseudo-Aggression")*
1. Used only in self-defense.	1. Used indiscriminately when an infantile pattern is repeated with an innocent bystander.
2. Object of aggression is a "real" enemy.	2. Object of aggression is a "fantasied" or artificially-created enemy.
3. No accompanying unconscious feeling of guilt.	3. Feeling of guilt always present.
4. Dosis: Amount of aggression discharged corresponds to provocation.	4. Dosis: Slightest provocation—greatest aggression.

5. Aggression always used to harm enemy.	5. Pseudo-aggression often used to provoke "masochistic pleasure" expected from enemy's retaliation.
6. Timing: Ability to wait until enemy is vulnerable.	6. Timing: Inability to wait, since pseudo-aggression is used as a defense mechanism against inner reproach of psychic masochism.
7. Not easily provoked.	7. Easily provoked.
8. Element of infantile game absent; no combination with masochistic-sadistic feelings; the only feeling is that a necessary disagreeable job has to be performed.	8. Element of infantile game present, combined with masochistic-sadistic excitement, usually repressed.
9. Success expected.	9. Defeat unconsciously expected.

I shall discuss now the specific points on the basis of a clinical example:

A patient of mine, a physician, called me one evening to inform me that his friend Dr. X, also a physician, wanted him to arrange an appointment for him to consult me because of his "personality difficulties," the nature of which was not specified in the telephone conversation. The appointment was made for the next day. At the appointed time the prospective patient appeared, and after introductions, started to shout in the waiting room: "I haven't the slightest confidence in you." I answered smilingly, "Well, this will be a short visit. Do you want to leave now?" The patient smiled, too: "No, let's have a talk." An observer would have classified the man's behavior as both irrational and aggressive; irrational because no one forced him to consult me without a minimum of confidence; aggressive because, being a physician himself, he was very sensitive to the upbraidings which physicians receive from patients. Asked why he had no confidence in me, he replied that the preceding evening he had had a theoretical discussion with the physician who recommended him to me, in which they could not agree on a specific type of narcosis. "Well, if an analyzed man talks such nonsense, his analysis can't have been a good one—though I'll admit that my friend has changed for the better in other respects." The senselessness of his argument was augmented when I asked him: "Was your little speech prepared?"

The man admitted that it was; in other words, his resistance was impersonal and rather unfair, because he didn't give me even a chance. "What would you have done to a patient who entered your office shouting in such a manner?" I asked. "I'd throw him out," was the prompt reply. "That was exactly what you wanted," was my conclusion. In other words, the man used pseudo-aggression to achieve masochistic pleasure. The naïve observer would diagnose his behavior as aggression, the analyst, as psychic masochism covered by pseudo-aggression. The whole life of this patient was based on that technique.

We see in this example all of the nine points enumerated in the table:

1. *Self-Defense or Prefabricated Pattern?*

No self-defense was involved for the patient, since the simplest way of defending his precious neurosis was to call off the appointment. His later analysis proved that he acquired the pattern of provoking conflicts in early childhood and repeated it later like a parrot. His technique was always the same: First he unconsciously provoked a conflict. Not being conscious that he himself provoked the conflict, he saw only the aggressive reaction of the person attacked, who, of course, fought back. With righteous indignation, the patient fought back on his side, seemingly in self-defense. As the final act he pitied himself, reflecting, "Such a thing can happen only to me." In this final self-pity he was, of course, unaware that he was enjoying the "psychic masochistic pleasure" of being mistreated.*

Psychic masochism—not to be confused with *perversion* masochism—denotes *unconscious* pleasure derived from failure, defeat, humiliation, rejection. Consciously, the psychic masochist has the best intentions to win success; his unconscious drives him in the opposite direction.

Psychic masochists operate unconsciously with eternal monotony on an identical schedule: First, they unconsciously provoke or misuse a situation in which somebody is "unjust" to them. Second,

*That triad of the "mechanism of orality" has been repeatedly described by the writer. For details see: Clinical approach to the psychoanalysis of writers. Psychona. Rev., 31:40-70, January 1944.

unconsciously ignorant of the fact that they have brought themselves into the lamented situation "behind the eight ball," they use a great deal of pseudo-aggression to ward off "unjustice" and fight in seemingly justified self-defense, bolstered by righteous indignation. Third, they pity themselves consciously considering themselves unique exceptions, the slogan being "This can happen only to me."

That triad, described by the author 16 years ago—and since—in a long series of publications, gives the afflicted person the ego-strengthening mirage of aggression, whereas it covers only unconscious masochistic enjoyment.

The unconscious reasons for the reaction are highly complex; it suffices to mention that clinically the type is well established. It has its basis genetically in undigested infantile aggression. That aggression was originally directed against the mother and father. Later, that aggression was curbed by external, and still later by internal forces, represented in the inner conscience. Instead of giving up what—in its effects—is dangerous aggression, with automatically-following retribution in the form of external, and later internal, punishment in the form of guilt, the neurotic child persists in his attitude. If this is practised for any length of time, the situation becomes untenable, simply because all human beings, including later psychic masochists, live on the basis of the pleasure-principle. *The only pleasure one can derive from displeasure* lies *in making pleasure out of displeasure*—that is, if one does not follow the normal course of relinquishing, if possible, the painful situation. Making pleasure out of displeasure is exactly what the psychic masochist does *unconsciously*: By sugar-coating the painful situation with a layer of pleasure, he gets some kind of satisfaction.

The sequence of events is this: First, there is aggression and the boomerang of aggression against the aggressive person himself. Here the process stops in normal children; the aggression is diverted and sublimated. In candidates for psychic masochism, a further development takes place: libidinization of the guilt for aggression. The whole process is, of course, fully unconscious.

2. *Real or Self-Created Enemy?*

In our example there was no real enemy involved, since the man wanted help from a physician; and by no stretch of the imagination could the helping physician be construed as an enemy. Therefore, the man merely used a harmless outsider for his unconscious repetion-repertoire.

3. *Presence or Absence of Feelings of Guilt?*

Neurotic aggression is always accompanied by unconscious guilt. The reason is that the original persons against whom the libidinous and aggressive wishes in childhood were directed were mother and father. For the more nearly normal person this attachment is practically resolved; therefore no guilt appears in "real" aggression, since the enemy is never identified with images from one's own childhood. Moreover, the normal person does not pick a fight *per se;* he defends himself when attacked, thus having the best of inner alibis. The patient described, on the other hand, immediately identified me unconsciously with a person in his childhood, as he revealed in his admission that his speech was prepared. Therefore the attack was "impersonal." As a result, he suffered feelings of guilt, visible in the quick collapse of his aggression when, as I was not playing his neurotic game, I refused to let myself be provoked.

4. *Discrepancy Between Provocation and Counter-Aggression?*

Normally one doesn't shoot sparrows with machine guns. Where a normal person teases or uses repartee, a neurotic one strikes. True, he strikes only to be struck back (and harder, for that matter).

5. *Harm the Enemy or Oneself?*

The normal person, if he fights, wants one thing only: to make a victim of the aggressor. What the normal person abhors most is pain, depression, guilt. For him, that trio is painful and disagreeable. He has no unconscious strings attached: Pain is pain. But for the neurotic, the situation is different. He craves "psychic masochistic pleasure." In other words, he makes pleasure out of pain. Without knowledge of this fantastic fact, neurosis is incomprehensible.

To give an example[7] from the analysis of a perverted masochist: A patient's masturbation consisted of striking his penis forcefully on the edge of the table and the more painful the procedure was, the more pleasurable it was. He brushed aside the objection that to a normal person pain and pleasure were exclusive of each other, and considered the analyst's statement that the patient's way of achieving sexual pleasure might be a punishment in a concentration camp, simply as the expression of "jealousy."

Imagine the same pleasure, consciously rejected but unconsciously approved, and we have a clue to the behavior of the physician of our example. He "hated" being mistreated, played the part of the "he man," but because of his unconscious provocation, was constantly "mistreated." In other words, he was a "psychic masochist" and not a "perverted masochist." Psychic masochism and perversion masochism are different entities.

6. *Waiting for the Propitious Moment Possible or Impossible?*

There is a clear-cut distinction in the timing of aggressive actions. The normal person more often uses the right, the neurotic person, the wrong, moment. The reason is that the normal person wants victory, the neurotic unconsciously wants defeat. The normal person strives for the current aim, the neurotic person for the current defense mechanism.[8] Therefore, to furnish his inner alibi, the neurotic cannot wait.

7. *Easy or Difficult to Provoke?*

The normal person has a fair-sized narcissism which protects him from outside criticism; the neurotic is "touchy" to the nth degree. Since the normal person does not start fights for the sake of fighting, but fights only in self-defense, he is relatively difficult to provoke. On the contrary, neurotics see an offense even where a normal person does not. In our example the patient felt provoked because of a divergence of opinions on narcosis.

8. *Presence or Absence of Masochistic-Sadistic Excitement?*

The normal person feels, in acting out his aggression in self-defense, that a necessary though disagreeable job has to be performed, nothing else. The situation is quite different for the neurotic person. He feels a queer excitement, often in the genital re-

gion. That feeling is often unclear to him—it is a combination of infantile masochistic and sadistic remnants. The element of an infantile game is discernible, whereas it is completely absent in such situations in normal persons. To be sure, the feeling of neurotic-sexual excitement (pain, tension, shrinking of penis or erection, infrequently even involuntary ejaculation) is more or less repressed; the defense against masochistic tendencies with pseudo-aggression is often the only surface reverberation. A patient, for instance, related a newspaper report of rape by colonial soldiers in a captured city, as if it were some amusing game. His logic told him that his feeling was shameful, but it was there. Analysis could prove he identified himself with the raped woman and secondarily warded off this identification with queer pseudo-aggression in thoughts. The element of the infantile game was very pronounced in this case. In the evening he felt a strong sexual urge and had intercourse twice, with fantasies centering around rape. Consciously, he identified himself with the raping soldiers, unconsciously with the victims. This can serve as a typical example of the warding off of unconscious feminine-masochistic wishes with pseudo-aggression, intercourse being misused for that alibi.

9. *Success or Defeat Sought?*

The normal person wants victory if he is forced to fight. The neurotic person seeks external defeat, which feeds his unconscious masochism. His victory is the achievement of masochistic pleasure. His self-constructed defeats are brought about by using arguments which boomerang—for instance, the illogical behavior of the patient in our example.

Neurotics fight their battles only to lose them. The consequences are far-reaching if one takes into consideration their lack of success, which includes also inability to enjoy even transitory success.

Knowledge of the differential diagnosis between normal and neurotic aggression is of decisive importance in the understanding of neurotic actions. If one confuses in psychotherapy the superficial pseudo-aggression of a neurotic with real aggression, and interprets to the patient only his "hostility" and "bellicosity," one cannot achieve therapeutic success.

Criminotic Aggression

The third type of aggression—the criminotic—is distinguished by the following characteristics:

1. It represents a subdivision of neurotic pseudo-aggression.* Proof positive is the fact that the alleged aggression damages the person executing the criminal act by his being caught or being in constant danger of being punished.

2. It is differentiated from neurotic aggression by the greater risk the alleged avenger takes: Whereas the neurotic bargains only

*The suspicion that the aggression of criminals covers a deeper conflict, is not new. Schilder and Keiser suspected it in *A Study in Criminal Aggressiveness* in 1936. They connected it however with more superficial factors, especially the fight against inner femininity. The authors come to the following conclusions: "... We conclude that in many instances *aggressive action is a reactive state resulting from a sense of passivity.* This passivity is frequently felt as identical with homosexual trends and fears of anal abuse, and is often felt by the individual to be synonymous with femininity. He therefore attempts to overcome his sense of femininity by acting out those attributes which are commonly considered the earmarks of masculinity, that is aggressive behavior.

"This original sense of passivity is at times reactive to overwhelming severity of the educative forces in childhood, so that none of the native aggressiveness can be expressed, but only one held in storage. This energy when released shatters all of the hitherto restraining forces and frequently becomes an exquisite expression of masculinity and aggressiveness.

"In others, a native physical weakness, or some abnormality, is so stressed that the individual feels forced psychically into a submissive role. But his aggressive forces also will not accept a denial of all outlets.

"That non-criminals can so easily express verbally their aggressive desires is indicative of the smoother flow of tension from aggressivity to passivity. There are no wide swings of the pendulum, but a moderate arc is described in the swing of their aggressive and passive impulses. The criminal expresses and frequently lives a markedly passive existence, save for, or until, his criminally aggressive acts. This is frequently observed in the adolescent hold-up boy. A fundamental causative factor seems to be our socially conditioned concepts regarding masculinity and femininity. A male needs to fight off any sense of femininity by physical activity—a masculine trait. Perhaps we can teach that both are present in all and that the one is no more expressive of femininity than the other is of masculinity.

"The organization of the ego plays an important part in the problem. The ego function can be impaired either by libidinous conflicts in childhood or by structural impairment. But the ideology plays an important part, as when the individual values physical fitness or prowess greatly, or when the environment approves of illegal violent behavior." (*Genetic Psychology Monographs*, XVIII, Nos. 5, 6.)

I believe that Schilder and Keiser dealt with the most superficial reverberations of a deeper conflict. The same holds true of Alexander's and Healy's studies embedded in *Roots of Crime*. For a discussion of the problem, see the author's: Suppositions about the mechanism of criminosis, Ref. 3.

for individual, consciously experienced unhappiness as punishment, the criminotic risks jail or capital punishment.

3. Social ostracism is involved in criminotic aggression, and not in neurotic.

4. In contradistinction to neurotic aggression exhibitionism plays an indispensable part in criminotic aggression. The majority of criminals are caught because of some "little mistakes" perpetrated by themselves. That unconsciously self-intended betrayal not only serves the inner guilt, it is also under the pressure of the exhibitionistic tendency to show the mother-image—shifted to society—that the child was capable of taking "revenge."

5. Childlike megalomania is more strongly represented in criminotic aggression than in neurotic. That is responsible for the criminal's attitude of considering himself as a unique exception as far as the danger of being detected is concerned. That megalomania, coupled with the unconscious wish to be punished, accounts for the incomplete thinking-through of the possibilities of detection and explains why a "perfect crime" cannot be committed.

6. The criminotic accepts inwardly the fact that he will be punished. Therefore one finds phenomenologically, so frequently, criminals seemingly without remorse and guilt.

So far, one may conclude that criminosis represents a specific "solution" of a repressed infantile conflict going back to the earliest months of life. The criminotic act is composed of two parts: a constant one (mechanism of criminosis), explaining the motor act, and a variable one, accounting for differences in psychological content. This psychological content is specific for the specific crime alone.

What about the *conscience of the criminotic?* Why does it not prevent the dangerous act? Does the criminotic have a conscience at all?

To begin with, a person without a conscience cannot and does not exist. Recent investigations prove conclusively that conscience is not at all a photographic copy of the environment, as previously assumed, but an inner institution having an intimate relation with the person's aggression. A part of this aggression is unconsciously curbed and redirected against the person himself.

To state that a person has no conscience, simply means that the investigator who made such a statement was incapable of finding out what hidden inner "deals" the "conscienceless" person made with his conscience to appease his conscience.

The personality of each human being wages a never-ending war with the *unconscious* part of conscience: *The Battle of the Conscience.*[9]

The term, "conscience," has scientifically a completely different connotation than that in popular usage. First of all, in general usage, people take only the *conscious* part of conscience into consideration, if at all. Everyone has a set of conscious ideal-precepts which—although they may be stretched frequently, very elastically—he tries to follow.

The unconscious conscience—the well-known super-ego—is something completely different. The language has not even an adequate word for it. The general ideas connected with conscience, as a restricting though benevolent institution, are not at all reconcilable with clinical facts.

To start with: Inner conscience is *not* a benevolent institution. It is obsessed with a lust to torture the ego; and it tries to extract the maximum of cruelty.

The question arises as to how free men came into this slavery and why that most cruel dictatorship should be maintained during lifetime by the victim himself. The paradoxical fact is observable that every individual creates and perpetuates his own "hell within him," to quote Milton.

Philosophers and introspective persons in general, have repeatedly expressed surprise, fear, disapproval (not to forget the results of their wishful thinking), when confronted with the "monster" of inner conscience. To quote a current statement:

"When I contemplate the accumulation of guilt and remorsefulness, like a garbage can, I carry through life, and which is fed not only by the lightest actions but by the most harmless pleasures, I feel Man to be of all living things the most biologically incompetent, and ill-organized. Why has he acquired a seventy-years' lifespan only to poison it incurably by the mere being of himself? Why has he thrown conscience, like a dead rat, to putrify in the well?"[10]

The Conundrum of Conscience

Different approaches have been tried to solve the conundrum of conscience.

1. The *religious* approach assumes a manifestation of God as the basis of conscience. Scientifically that statement can neither be proved nor disproved clinically and therefore is outside the realm of science. If a religious man of any denomination asserts to the scientist that without the pre-ordained will of God, education and intrapsychic mechanisms could not have built up the phenomenon called conscience, the discussion stops at that point. Religious beliefs are the most private affairs in a man's life. Science is neither competent nor willing to argue outside its own circumscribed zone. Hence, respect for the convictions of others—as well as the knowledge of having little to contribute to the emotional experience of the religion accepted in his specific society—debars the scientist from further argument. Science and religious beliefs work on entirely different psychic levels, and should stay in their respective domains, as far as scientific and religious polemics go. The two approaches do not contradict each other, as is shown by the fact that there are scientists who are deeply religious.

2. The next approach may be labeled: *conscious identification with the specific environment.* Here stress is put on consciously performed imitation. Parents and educators provide a set of rules for the child, implemented by good examples. The difficulty here is based on the clinical observation that in many cases, though constantly confronted by "good examples," the child behaves contrariwise. It remains unclear why one child accomplishes the identification, the other not; why one child comes under "bad" influence, whereas the other remains immune under identical conditions. Moreover, it remains more than doubtful whether the identifications, if accomplished, are of the conscious type. Every child is confronted with good and bad examples alike, not all "take" to them. Contradictions are rampant as to effects, as visible in the opinions of "simpleton sages and reasoning fools" (Thomas Moore), accumulated through long centuries and quoted by philosophers and poets. For every optimistic statement, a pessimistic one can be cited, as the following table illustrates:

Optimistic Views

La Rochefoucauld: "Nothing is more contagious than the example. We are incapable of doing something extraordinary, be it good or bad, which in turn does not produce something similar. We copy the good because of our tendency toward imitation, the bad because of the viciousness of our nature, a viciousness which was imprisoned by shame and set free by the example."

Smiles: "Example is one of the most potent of instructors, though it teaches without a tongue."

La Fontaine: "Example is a dangerous lure; where the wasp got through, the gnat sticks fast."

Tertullian: "*Bonos corrumpunt mores congressus mali.* (Loose translation: 'Bad examples corrupt good behavior.")

Samuel Johnson: "Example is more efficacious than precepts."

Pessimistic Views

Nietzsche: "No one can draw more out of things, books included, than he already knows. A man has no ears for that to which experience has given him no access."

Hegel: "People and governments have never learned anything from history or acted on principles deduced from it."

Oscar Wilde: "Experience is the name everyone gives to his mistakes."

Publius Syrus (approx. 42 B. C.): "Many receive advice; few profit by it."

Chevalier de Panat (about the Bourbons after their restoration): "*Ils n'ont rien appris ni rien oublié.*" ("They did not learn anything, nor have they forgotten anything.")

The whole problem of "bad influence" and "good advice" is in general misunderstood.[11]

Popular opinion holds that good behavior results from avoiding "bad influence" and "bad examples" and receiving "good advice" freely. The excuses, "I got into bad company," and, "Nobody advised me properly," are, for many, a satisfactory explanation of actions of doubtful wisdom.

The psychiatric approach is less naïve. We ask, first, why the "bad example" has such devastating effects in one case when it does not have such ill effects in another; second, why the maximum of "good advice" given to a specific person "does not take" when its absence for other persons does not prevent them from doing the right thing "instinctively." In short, we reduce the general external problem to the specific inner problem of the individual.

What is the psychological situation of a person when presented with either good or bad example? In the first place, the example *per se* has not the slightest influence on the psychic apparatus.

What can happen, however, is the coincidence of two factors: For unconscious reasons, completely unrelated to actual events leading to the good or bad example, a specific person can be ready for an unconscious identification. Then, and then only, the example has effect and is followed by what the unpsychologically-trained observer erroneously calls imitation. Hence the problem reduces itself to the psychology of unconscious identification.

Unconscious identification denotes the taking over of another's opinion or the repetition of his actions without conscious awareness of so doing. The pupil who copies antics of his teacher, imitates his voice or opinions, acquires these traits by way of unconscious identification. If someone draws attention to this imitation, the imitator will indignantly deny it, and with good reason. He speaks for his consciousness and this did not perform the identification; something happened behind the scenes of his personality.

A person setting a "good" or "bad" example offers himself, without knowing it, as a model for identification. A few clinical examples will clarify the process:

A patient, a poor orphan at the age of one and one-half, was brought up with his wealthy cousin. Both boys were strongly attached to the mother of the rich boy, but lived in constant fear of the father, a rigid, cold individual who was always preaching. At the age of five, the orphan came under the "bad influence," as the family put it, of a male servant, imitating him in theft and swindling. A strong identification with the servant was discernible. Analysis proved that, preceding this identification, the boy had developed a strong Oedipus complex (attachment to the parent of the opposite sex, in this case the boy's aunt), and had been driven out of this libidinous position through "fear of castration" (Freud) by the potential threat of the punishing uncle. The boy had then identified ("negative Oedipus") with his aunt, a kind, submissive woman. He could later remember that at the age of four he had been teased because of his shyness and "girlishness." A few months later his behavior had changed once more; he had become provocative, a miniature truant and a delinquent. His family attributed this change to the influence of the servant, and dismissed the man. However, the boy continued to cheat and steal

until late in life. We see in his case both the "good example" (represented by the hyper-moral uncle) and the "bad example" (the servant). From the descriptive viewpoint it is not understandable why the boy finally chose the "bad example" with which to identify. Theoretically, both possibilities for identification were present at the same time. From the genetic viewpoint his choice is understandable: Instead of giving up his incestuous wishes and identifying himself with the prohibitor-uncle (the process leading to normality), the boy identified with the woman, thus accepting "castration" as a punishment. This identification was counteracted by a strong inner feeling of guilt, so that a new alibi-identification had to be established proving his "aggression." Therefore, he identified with the pseudo-aggressive servant.[12] However, his passivity was smuggled into the defense: Through stealing and swindling, he came into deeper conflicts.

Another example: The son of a well-known historian devoted his life to proving that all history is based on fallacy, thus belittling his father's life-work. There were constant "scientific" conflicts between father and son. The son gleefully quoted statements disparaging the accuracy of historians. His favorite quotations were: "History is a fable agreed upon" (Napoleon). "On the breast of that huge Mississippi of falsehood called history" (Matthew Arnold). "History is bunk" (Henry Ford). The father was furious when his son quoted, first in conversations, later in his writings, the witty "anonymous" sentence: "History is something that never happened, written by a man who wasn't there." It was obvious in analysis, that the son's spiteful approach to his father's profession had as its basis, not an intellectual, but an affective conflict. The young man was inwardly deeply submissive toward his father ("negative Oedipus"). He warded off this attachment with pseudo-aggression: "I'm not submissive toward my father; quite the contrary, I hate and ridicule him." Hence the irony directed against his father's profession. Here, too, two possible objects of identification could be discerned, the father and a cousin, an inhibited writer who constantly made "cracks" at the expense of his more successful relative. The sequence of events in this case was: neurotic solution of an inner conflict; use of an

identification with a "bad influence" as a prop ("Other people don't believe father, either").

As a third clinical example, let us consider a young woman from a puritanical family, who, in a specific period of her life (between the ages of 24 and 27), practically lived the life of a nymphomaniacal prostitute. She had sexual relations indiscriminately, was frigid and insatiable. The question arose as to why she did not identify with her puritanical mother. It turned out that she did have this identification at first, but that it was later shattered when her mother remarried. The father died when the patient was three. From the ages of three to six the patient lived alone with her mother, was completely under her influence, and "loved her dearly." The mother's remarriage was perceived by the child as an act of abandonment and loss of love. She treated the step-father coldly and even with hatred, as if he had "stolen" the mother. The hatred for the mother was bolstered by different influences: The old hatred stemming from the normal Oedipus complex had developed during the first marriage; the father's death brought forward an intense feeling of guilt, with reactive submission toward the mother, since the child had previously wished her death. The second marriage activated the old Oedipal wishes, which were warded off by coldness toward the step-father. The child early developed symptoms of an obsessional neurosis, believing that she was "cursed." The first man she had loved (the father) had died. One of the many reasons for her constant change of lovers was a protective mechanism: If she were to stay longer with any one, her own father's fate would overcome him. On a more superficial level, she identified with an aunt, a sister of her mother, the "black sheep" of the family. This woman spent most of her adult life in Europe instead of settling down in Boston, as was expected of her, and was followed by rumors of "Continental affairs"—a euphemism for illegitimate love affairs.

We see once more in this case, which was near manifest homosexuality, that the good example of the mother and the bad one of the mother's sister had no influence in themselves but were alternately used as props for inner conflict-solutions of the child.

To understand fully the effects of "bad influence" crystallized in "bad examples," we must take into account the fact that the in-

dividual spends a great deal of his psychic energy in fighting his inner conscience. The inner conscience (super-ego) is not exactly a benevolent institution, as Freud pointed out: "The super-ego seems to have made a one-sided selection, to have chosen only the harshness and severity of the parents, their preventive and punitive functions, while their loving care is not continued." To live in peace with one's own conscience, presupposes constant checkmating of that inner department of the personality. This is normally achieved by avoiding too many conflicts with the super-ego's demands and by using a part of the inner aggression to ward off the super-ego's reproaches. In neurotic conditions, although the super-ego is constantly appeased by suffering and depression, it still does not leave the victim in peace. The ego is, therefore, forced to furnish ever new weapons against its chronic tormentor. These weapons are numerous. One of the possibilities is the constant "showing up" of the super-ego as hypocritical, by pointing out that other "authorities" (the super-ego is built partially by introjections of parental authorities) are not so innocent either. If, therefore, in such a situation of inner conflict a "bad influence" is at hand, an inner identification can take place as an episode in the fight with the inner conscience. The "temptation" of the bad example is thus used as an intrapsychic weapon against the severe inner conscience and not, as is naïvely assumed, merely as a release of repressed wishes.

We see, therefore, that the presence of "good" or "bad" examples does not suffice *per se* to bring about good or bad behavior. Examples are used or misused according to the specific unconscious needs of the specific individual.

Not very different is the role of "good advice." First of all, good advice is always met with mistrust, particularly by neurotics. The reason is that these people have never overcome the feeling that their parents were hypocritical; for instance, forbidding sex to the children, being horrified at it, but indulging in it themselves. One neurotic patient quoted Heine: "They preached water and drank wine." Another called his father the "vote dry and live wet" type. Another patient consulted a gynecologist in Paris for information about contraceptives. Upon receiving the information, she remained skeptical, believing that the doctor had two

types of advice: that which he used for patients and that which he used himself. In other words, she projected the idea of parental hypocrisy on the physician.

There is a hopeless contradiction in the external setting of getting good advice. Good advice can reasonably be given only by older people, who have burned their fingers repeatedly. On the other hand, the people seeking advice are mostly younger people, who are very distrustful of their elderly advisors. One patient discarded all advice with La Rochefoucauld's famous statement: "Old men are fond of giving good advice to console themselves for no longer being in a position to give bad examples."

Besides that *a priori* doubt, the fact remains that people just don't have an organ for accepting experiences which they themselves have not lived through. Moreover, people do not really learn from their own experiences, popular contrary-assumptions notwithstanding. And, of course, other people's experiences just "don't count," at least affectively. Otherwise, how is it understandable that every generation repeats the mistakes of its forefathers, and that individuals so often make the same mistakes repeatedly?

We often encounter the idea that logic must and can convince people. Nothing is further from clinical experience. The overvaluation of logic is based on ignorance of unconscious factors. Everybody makes all the mistakes which the psychic masochism embedded in his neurosis forces him to make, which though in other circumstances might be avoidable, are in the specific case inevitable because of unconscious reasons. I once analyzed a man who habitually lost money by lending it to "friends" who proved to be unreliable. The reason was that unconsciously he had the need to prove himself how unjustly he was treated, in repetition of an infantile situation. "How often must I repeat this nonsensical situation?" asked the patient in great distress when caught once more in his vicious circle. "As long as you cling to your neurosis," was the simple answer.

Amusingly enough, some neurotics believe that being penitent and promising themselves to accept and follow good advice, helps them. Of course it doesn't. Some neurotics even rationalize their defeats on the ground that they are "superior" people. One such

patient quoted Luther: "Great men owe God one great mistake for which they have to pay dearly; no great man makes a simple mistake." "On this basis you are permanently 'a great man,'" was my reply.

"Good advice" is, in general, so ineffective because it conflicts with the child-like megalomania deeply embedded in every individual. It is surprising how many people go about with the unconscious belief that they alone are "exceptions," to whom human experience does not apply. For these people "experience" consists of a hopeless attempt to reconcile the irreconcilable: fantasy to facts.

Must we draw the conclusion that good advice and examples are worthless? Of course not. What we must guard against is the naïve belief that facts *per se* make any impression on the individual. Only insofar as these facts fit into the normal or neurotic picture of the personality, are they effective. If a person is normal, he identifies with his educators. Only in this circuitous, unconscious way are "good examples" and "good advice" accepted and "bad examples" and "bad advice" neutralized.

3. *Early psychoanalytic theories* connected the development of conscience with the normal overcoming of the Oedipus complex. Freud assumed that every child goes through a period in which it attaches libidinous wishes to the parent of the opposite sex, and aggressive-competitive tendencies to the parent of the same sex. These wishes are detached after the age of five; they are shattered on the castration complex. To take the example of the boy: He is afraid of his father's retribution and prefers the intactness of his bodily integrity to the not-realizable wishes directed toward the mother. The result of that conflict is that the maternally-directed wishes are de-sexualized, deprived of the previous libidinous content,* and the father's prohibitions are internalized; and thus the inner conscience is established.†

*The child has, of course, different misconceptions of what parental sexual activity consists of. These misconceptions have little to do with adult intercourse.

†*Mutatis mutandis,* the same process was assumed to take place in the girl, although the severity of feminine conscience never reached that of its masculine counterpart, according to that conception.

4. *Later psychoanalytic theories* stressed the fact that the child does not perceive reality as it really is, but through the spectacles of "projection."* Projection denotes unconscious shift of a person's inner problem to the outside, without awareness of so doing. If, for instance, the boy experiences great aggression toward his father, he may shift that aggression projectively on the father and now feel that the father is "cruel." If the boy later introjects and incorporates the father's prohibition, the severity of the inner conscience so formed is in direct proportion to his *own,* and not to the father's, aggression.

Other theories stressed the assumption that the child shows signs of the existence of the super-ego long before the age of five, that the super-ego antedates the development of the Odipus complex, and is, thus, brought into connection with the mother.

The decisive element in the structure of the super-ego has been more and more understood to be its fantastic severity. To quote a late statement of Freud: "The super-ego seems to have made a one-sided selection and to have chosen only the harshness and severity of the parents, their preventive and punishing functions, while their loving care is not taken up and continued by it."

Freud finally came to the conclusion that every bit of aggression which—under cultural conditions—cannot be placed externally, is taken over by the inner conscience.

5. *Freud's Eros-Thanatos theory* assumes that there are two basic instincts operative in every human being. Our whole life consists of a constant fight between two giants: the "life-instinct" (Eros) and the "death-instinct" (Thanatos). Eros attempts to discharge upon objects in the outer world the destructive tendencies of Thanatos, originally turned upon the individual himself. What is apparent as an instinct of destruction is genetically the original death-instinct, forced into a changed direction by the life-instinct. Guided by Eros, the destructive instinct rages outwardly, instead of inwardly.

Imagine two giants fighting each other; the first wants to kill the second. The second tries to divert the destructive energy of the first toward a third party. Imagine further both giants operative as instincts in one personality, and you have in a nutshell the Eros-

*Especially emphasized by the English school of analysis.

Thanatos theory. These drives never appear "unmixed." They are combined in quantitatively varying degrees at different times. There is also an "indifferent narcissistic energy" which can be added to one drive or another, thus increasing its cathexis. Of course, what we see clinically is never life-instinct or death-instinct *per se,* or even their original mixtures, but only the derivatives of these mixtures. In this sense we can speak of "libido" and "destrudo" (aggression), assuming that each contains admixtures of both drives, libido more of the derivatives of Eros, destrudo more of the Thanatic elements.

Freud himself did not apply this theory to the development of the super-ego. This was done by two of his pupils.

6. *The Bergler-Jekels theory* represents an application of Freud's dualistic Eros-Thanatos theory to the development and working of the super-ego.

Freud's original conception of inner conscience was based on a compromise between the original megalomania of the child, confronted with a stronger reality, represented by the parents. The child solved that conflict by a face-saving device: He identified himself with the commands of these educators, sugar-coating the defeat by an illusion. That illusion is: Nobody forces me, I'm good of my free decision. The amalgam of infantile megalomania and introjected educational rules was called *ego-ideal.*

The ego-ideal later became submerged in the newer concept of the super-ego. The relation between ego-ideal and super-ego was never clarified.

The Bergler-Jekels theory *assumes that the super-ego consists of two distinct parts: the ego-ideal and the "daimonion."* The latter term denotes the anti-libidinous parts of the conscience, loaded with derivatives of the death-instinct. The term is derived from Socrates' "daimonion": That philosopher believed that some kind of malignant spirit raved inside the personality. That mythological conception has—taking the death-instinct into consideration—a very real meaning.

The interconnection between ego-ideal and daimonion is this: The ego-ideal was originally created to maintain the threatened narcissism of the infant. It enshrines all the childish ideas of

grandeur, all the promises the child gave himself of the great and wonderful deeds he would perform and achieve in this world.

Unfortunately for the ego, the daimonion takes the high-pitched expectations of the child, accumulated in the ego-ideal, very seriously. Mockingly, it presents the ego-ideal to the ego and asks: Did you reach everything you promised yourself? Since the ego-ideal practically never can be fully materialized in this real world, the ego-ideal thus becomes an instrument of torture.

Daimonion holds up to the ego the self-created ego-ideal like a silent mirror; and every discrepancy between ego and ego-ideal is felt as depression, dissatisfaction, guilt.

Derivations of the life-instinct, accrued in the ego-ideal, fight a losing battle with derivations of the death-instinct, symbolized in the daimonion. The irony in the situation is that the daimonion uses life-instinct—the ego-ideal—for its destructive purposes. The ego is caught in his own—and self-created—protective apparatus.

The super-ego, once established, is an *internal Frankenstein,* constantly ready to spring upon the poor ego. Still, there are certain restrictions—one could speak of "rules of torture"—governing that monster.

First of all, the super-ego is extremely formalistic in nature. It could—since it has the power—torture the personality simply because it is in the driver's seat. It does not, but adheres to the comedy of a *mock trial.* It always presents to the ego its ego-created dupe of an ego-ideal, asking the monotonous question: *Do you admit that there is a discrepancy between your ego and ego-ideal?* If that discrepancy cannot be denied, punishment in the form of guilt is imposed.

Why that comedy of intrapsychic justice is instituted, can only be dimly surmised. First, it is possible that the super-ego's cruelty is counteracted by tendencies of the life-instinct, forcing it, to make the "compromise"—in form. That assumption is based on theoretical considerations in cases of suicide[13] where, according to Freud, "a pure mixture of death-instinct reigns in the super-ego." That de-fusion of instincts leaves the death instinct no longer attenuated by the life-instinct. Another reason for the super-ego's adhering to "rules of torture" is, perhaps, the fact that, because of the counteraction of the life-instinct, the super-ego must pre-

vent a possible slave revolt of the tortured ego. Obviously the ego is more manageable when its "self-written check" is presented.

Second, the super-ego *never punishes* the ego *without proving that the varying forbidden wish is really harbored in the reservoir of unconscious wishes, the Id.* Any denial is impossible because of the direct "pipeline" between super-ego and id. Precisely the fact that the super-ego knows so much of the person's innermost secrets, makes the unconscious conscience such a formidable enemy.

To compensate for that pseudo-restraint, the super-ego *does not distinguish between wish and deed.* The tragic result is that the internal "criminal law" is more severe than the external one, which does not prosecute sins "committed in thoughts." That "infernal-internal thought-police," as a witty patient called it, leads to most tragic consequences: *Nine-tenths of neurotic guilt pertain to unconscious fantasies only.*

Third, the super-ego *adheres ironically to "freedom of will,"* as far as the victimized ego is concerned. It pushes the victim indirectly—by relentless vigilance—into an impossible and self-damaging situation, turns the tables and asks indignantly: How could you do that? It acts, in these accusations, as if the action perpetrated were under perfect conscious volition.

Fourth, the super-ego camouflages its cruelty by *accepting "cultural standards"* fashioned after the specific environment. That makes it possible for naïve observers to make the faulty deduction that the individual is the product and mirror of his environment. Assuming for the sake of argument that the super-ego is basically interested in torturing the ego, what difference does it make whether the super-ego uses this or that prohibition based on specific taboos of the specific environment? The common denominator is still a series of "Don't's."

On the other hand, the acceptance of the specific taboos—different in different cultural orbits—imposes an odd restriction on the super-ego. Anti-libidinous, as the inner conscience is, it is helpless against actions approved by the specific environment.

Fifth, the super-ego is impressed by success—though it is the typical *devaluator of success,* if it is incapable of preventing it in the individual. It is a well-known fact that many people are in-

capable of enjoying self-achieved victories. They start to doubt whether the expenditure of effort in the game has been "worth the candle." This is mostly the belated "contribution" of the super-ego.

Sometimes, that tendency goes so far that the super-ego makes fun of its own punitive executive organs. It acts like a gangster who extracts at gunpoint the signing of a detrimental document—only to show the victim later that the gun was really a camouflaged cigarette container.

Sixth—last, but not least—the super-ego is extremely *sensitive to real aggression,* when directed against His Majesty, the tormentor. Being constituted of malicious aggression itself, it understands one thing only: the fist with real power behind it. That is clearly visible in so-called normality as compared with neurosis. In normality, the ego has a good-sized quantity of real aggression at its disposal; hence the not-too-neurotic person has not too much to suffer under his inner tormentor. In neurosis, the balance of power is precisely reversed: The super-ego usurps the person's aggression and tortures the ego.

Even under the most favorable conditions, in normality, the ego uses a great deal of its psychic energy—mainly aggression—to ward off unjustified reproaches of the super-ego.

The super-ego is, thus, not simply a necessary restrictive institution, a necessity readily understood and approved. *It is the anti-hedonistic force in the personality, loaded to capacity with derivatives of the death-instinct.* The observation that it represents restrictions seemingly embodying only the specific taboos of a specific environment, is a mirage. That is the anti-libidinous blind for its punitive actions, attached secondarily as hitching posts to reality-restrictions. Its *prime movens* is the formula: No pleasure.

All of this applies to more or less normal people. The moment clear-cut *neurotic reactions* are involved, a different picture appears.

Neurosis is an anachronistic disease of the unconscious, preserving repressed infantile wishes, defense mechanisms, guilt. These old, normally relinquished, or, at least, modified tendencies are unconsciously perpetuated, though constantly counteracted by a severe super-ego. *The latter is, however, under neurotic condi-*

tions, meretricious and venable. Like a corrupt district attorney, it can be bribed, bought off, and appeased. The intrapsychic currency is, of course, not money—the very young child does not yet know the value of money. The currency in the nursery is love and punishment. *Hence the inner conscience is partial to punishment.* The neurotic "deal" consists precisely in the tenacity of id-wishes, ego-defenses, super-ego-corruptibility. Simplified in caricature, the neurotic structure rests on a compromise like this: Under the condition that the super-ego is bought off with consciously experienced depression, dissatisfaction, ego-restriction, the super-ego allows innuendos of unconscious pleasures—though not in direct form—screened by a defense mechanism against these repressed wishes.* The super-ego gets his full share of punishment, the id receives attenuated wish-fulfillments, camouflaged in unconscious defenses. The neurotic pays an exaggerated fee for infantile, second-hand, substitute gratifications.

Every neurotic conflict is characterized by:

(a) The *unconscious fantasy,* materialized in second-hand *innuendos,* is of early *infantile origin.*

(b) The conflict has an "uncanny" tendency to *repetitiveness.*

(c) The neurosis is a *progressive and not self-limiting disease;* responsible for that fact, is the cruelty of the super-ego which—given the static id-wishes—extracts, as time passes by, "higher rent" in the form of greater punishment, which in turn forces the unconscious ego to give ever new alibis in the form of new defense mechanisms.

(d) The neurosis manifests itself either in symptoms and signs (*symptomatic neuroses*) or in *personality difficulties* (*character neuroses*), or in a combination of both.

(e) The neurotic conflict is—without psychiatric help—*indestructible.* The symptoms may be exchanged, the sum total remains identical or even increases, as time passes by.

*Older analytic theories assumed a two-layer structure: Neurotic symptoms and signs were considered direct symbolic "substitute gratifications." I personally believe that a three-layer structure is involved: repressed wish-symbolic defense—defense against the symbolic defense. Only that secondary defense appears in consciousness as "strange" symptom and sign. For a discussion of the problem see: *The Battle of the Conscience,* loc. cit., Ref. 6.

The Criminotic Conscience

How does all that apply to the *criminotic conscience?* The criminotic conscience, being a specific case of the neurotic conscience, is in the same way corrupt and capable of being bribed and appeased. The bribe consists of complete acceptance of punishment meted out by the projected super-ego, the legal and penal authorities. *Every criminal bargains unconsciously for the electric chair, the gallows, the firing squad. Hence the conscious deterrent of punishment is no deterrent at all, but a part of the criminotic's unconscious motivation.*

Every human being has a conscience, and a severe one, for that matter.

The cynic, "the man who knows the price of everything and the value of nothing," to quote Oscar Wilde, who knew well, tells us that the inner conscience is just an agreed-upon fable. He cites in his argument the cases of criminals, with or without acknowledged social position, whose "hard-boiled" actions can hardly be described as being influenced or restricted by conscience. And still, interestingly enough, the majority of outstanding criminals of the political or simple murderer variety, end in the electric chair, at the gallows, or before firing squads. In other words, the cynic does not look far enough; he focuses his attention on the *initial* action, does not take into account the fact that initial actions are possible only on the *unconscious* condition that *final* detection and punishment must be reckoned with. Every criminal bargains *unconsciously* for the electric chair. Of course, he is not aware that he does so, with the result that the cynic (Nobody is more easily fooled than the cynic!) comes to false conclusions, believing the criminal's rationalization.

Psychoanalytic investigation confirms the consoling intuitive belief of humanity that *everyone has an inner conscience and is constantly under the influence of that inner department of the personality.* A feeling of guilt follows every person like his shadow, whether or not he knows it. This statement may sound absurd if one looks only at the initial action and is taken in by the braggadocio of the wrong-doer, expressed in his actions, appearance, words, and posture. If one looks at such an individual with the

analytic microscope, however, a completely different picture appears. Every member of the detective force knows that the most clever criminal will make his "little mistake" somewhere, a little mistake leading to detection. No "perfect crime" is possible because of the counteraction of the *unconscious* part of the conscience, demanding detection and punishment, the very detection and punishment which the criminal tries so hard consciously to avoid. The old saying, "You can get away with murder," is not borne out by the statistics of detected and undetected crimes.

The cynic concentrates too much on his chief but spurious explanation, criminality, and overlooks, in so doing, two facts. First, that his own cynicism has unconscious reasons, too. Second, that the real psychological problem of determining the existence of conscience is not whether people react *immediately* to the influence of conscience—undoubtedly the ideal situation—but whether they have to use devious unconscious means to appease this conscience. This is a fertile field for investigation to which the cynic is blind. No less blind is he, in differentiating between the *conscious* and the *unconscious* parts of the conscience.

Action proves the man—only insofar as he is not too neurotic. As far as the majority of neurotics are concerned—and neurotics comprise a sizable part of the population—one cannot understand their inner structure from their actions alone; one must know the unconscious background and what self-punishment they are unconsciously intending.

Self-destruction in criminotic disguise is no argument against the existence of conscience. It is a proof that the consciences of the criminotic, the neurotic, and the so-called normal work differently. True, what decent people want to achieve is the prevention of criminal actions from the start by means of conscience. Conscience does achieve that, in not too neurotic people. The tragedy of the man killed by the gangster is not mitigated by the knowledge that the gangster was capable of killing him only because of the unconscious imperative that he himself will be killed too, by legal process.

The last problem is the degree to which the feeling of guilt is the simple consequence of a criminal deed. How complicated this problem is, becomes visible by comparing the following statements:

Schilder and Keiser: "We have no definite reason to believe that the wish for punishment, although present, is one of the outstanding factors. . ."[14] "As with most criminals, he wants to be punished, but not too severely. It is the attitude of the child, who regains the love of his parent after punishment."[15]

Zilboorg: ". . . As soon as the impulse is discharged and the special Id drives are thus temporarily gratified and silenced, the Super Ego re-establishes itself and asserts its demands. Even the hard, defiant criminal then feels unconsciously repentant. His challenging, snarling, boisterous defiance of the law, or his sullen, apparently indifferent, emotionless attitude is in most cases but an automatic covering, boastful or humbled, of the sense of guilt. The writer has never failed to find it deeply buried in the unconscious of apparently confirmed criminals of whom he had the opportunity to make a psychological study within the walls of a prison. Many criminals, as a result of this inner penance, kill themselves soon after the crime. . ."[16]

I personally disagree with all three authors with regard to the deposition of the feeling of guilt. I disagree with Schilder and Keiser, since I believe that the *unconscious feeling of guilt has the place of pivotal importance in criminal deeds and is automatically included in the deeds.* If the criminal did not know unconsciously that he would be punished, if he did not project his expected punishment upon the juridical and penal authorities, making them the executive organ of his own super-ego, his feeling of guilt would prevent his deed in the first place. Only *because* he projects this expectation of punishment does he often appear detached, and sometimes without penitence. I disagree with Zilboorg's concept of crime. For him, the criminal action represents a volcanic eruption of repressed id wishes followed by the feeling of guilt. In my opinion, crime is not the outburst of an id wish but a defense against it, executed by highly complicated means. The feeling of guilt does not appear *post facto* but is embedded in the deed itself. *Only this unconscious expectation of punishment makes the criminal action possible.*

And the practical application of all of these theories, hypotheses and suppositions?

To make our problem more difficult, there are on record, with few exceptions, no actual clinical analytical experiences with criminals in prison. With the exception of a few attempts no organized analysis in prisons has been conducted.* The result is that, in general, clinical experience is lacking; and theoretic misconceptions and ignorance are rampant. Such ignorance seems strange, since there is no lack of inmates in prisons, nor lack of experienced psychoanalytically-trained psychiatrists who could work a few hours a day at prevailing rates in order to conduct such exploratory analyses. The only things which are missing are money and an organization to set the undertaking in motion. Some time ago, I proposed that a fund should be raised to enable 50 psychoanalytically-trained psychiatrists to analyze for two years 500 criminals of all types in prison. A cross-section of the material obtained in such an experiment might reasonably give the hope of some general agreement as to conclusions. The experiment would have to be conducted by a large group of physicians; one conducted by a few, analyzing the same number of criminals over a longer period, would not be conclusive, since every physician involuntarily brings his preconceived ideas and personal scotomata into play. A cross-section of the findings of *many physicians* would be an indispensable prerequisite.

The case material collected so far in the clinical psychoanalyses of criminals is so insignificant in amount, so inconclusive in results, that it simply excludes any possibility of basic conclusions, even if one overlooks the contradictions in the conclusions made by different authors and achieved through differing approaches.

Some authors compensate for prevailing ignorance by overoptimism, some by overpessimism, concerning the future possibilities of the therapy of criminosis. *The simple fact is that we just don't*

*Among these few exceptions are the analysis undertaken by Foxe, described in: Psychoanalysis of a sodomist, Am. J. Orthopsychiat., 1941; and his analytic experiences with 35 criminals, described in his monograph, *Crime and Sexual Development*, Glens Falls Monograph, 1936; Alexander's and Healy's half-year experiment with a few cases of stealing: *Roots of Crime*, Knopf, New York, 1935. Schilder and Keiser drew conclusions from unanalyzed murderers sent for observation to Bellevue, *A Study in Criminal Aggressiveness*, Genet. Psychol. Monograph, XVIII, Nos. 5 and 6. And lately, Lindner's hypnoanalysis of a criminal psychopath, *Rebel Without a Cause*, Grune and Stratton, New York, 1944, is another instance. Lindner mentions five similar cases.

know. I personally feel mildly pessimistic about future successes in treating criminotics. My doubt is based on the difficulty of changing even those neurotic patients who have a great amount of self-damaging tendencies—for the most neurotic individual uses a different, but undoubtedly *less* self-damaging, technique than the criminotic. The vast amount of psychic masochism in criminals makes me suspicious of their curability. I should like to mention two illustrations of their therapeutic inaccessibility, the one reported by Alexander and Healy, the other from my own experience. In *Roots of Crime,* the two authors mention the case of a young man who, after hearing of the possibility of being analyzed in prison (the experiment was publicized), gave himself up in order to undergo analysis, received a two-year prison term for previous offenses (there were warrants out for him), but discontinued analysis after a short while with threadbare excuses.

My own experience was as follows: In a psychoanalytic clinic many years ago we had the opportunity to observe a "mass experiment" on a small scale, supplied, strangely enough, by a regular court. There was, at that time, a judge who harbored the naïve idea that psychoanalysis could cure any perversion, even *without* the patient's co-operation. For a time, therefore, he did not sentence perverse exhibitionists, who offended repeatedly, to the rather long prison term usually imposed. Instead, he passed suspended sentences and remitted punishment if they could prove after six months that they were under psychoanalytic treatment. Five cases were sent to the clinic, where they were to be treated free of charge. Of these five persons who faced the alternatives of imprisonment or psychoanalysis, one began analysis with one of my colleagues and promptly gave it up a few days after receiving the written confirmation that he had begun treatment. Two others did not appear after the first interview with the head of the clinic. With the two remaining, I spoke once or twice. After being told that they could start treatment, they withdrew with the most patent excuses. All five allowed themselves to be imprisoned. How can this grotesque situation be explained? Even fear of the alleged unpleasantness of the treatment cannot be given as the reason for the behavior of these five individuals, since they had no idea of what the treatment consisted. They could not have had

any antipathy for the particular physician who would treat them, since each spoke with three physicians on the staff at the clinic. Nor was there a conspiracy to refuse treatment, for there was no proof that they even knew each other.

From the discussion I had with two of them, I received the impression that imprisonment from time to time was an inseparable part of their psychic equilibrium. It gave them the opportunity to atone for their inward feelings of guilt. The prison term gave to them, so to speak, the ticket permitting their next perverse action. Also striking, was the awkwardness of their behavior when they were caught. They actually provoked arrest. One of them, for instance, was threatened by an old woman who saw his exhibitionistic act with a child from the window of a third floor. The man ran away, but returned in a few minutes, his rationalization being that he wanted to see if the old woman was still there. She was exactly where he suspected she would be—with a police officer, who arrested the man.

Not only was imprisonment preferred by these two sick individuals, but it had become part of the routine of their lives. One of them had a small business, delivering packages by car. When the occasion arose for a prison term, he told his family that he had to make a business trip into the country. The "business trip" was undertaken in jail. Another worked in his brother-in-law's print shop; and he was able to convince him that he had to take a trip occasionally to the mountains in order to keep fit. In this instance, the vacation was spent in jail. One could not but feel that treatment would obviously have disturbed the vicious circle of unconsciously self-provoked punishment, with the license it gave unconsciously to continue the perversion.

These examples show why one must have some doubts in respect to a future therapy of criminals. Judicial punishment is in some cases not punishment at all but unconscious temporary solution of a guilt conflict. The punishment is not dreaded but unconsciously expected by these sick persons.*

*Interestingly enough, Freud suspected as long as 30 years ago that some criminal actions were performed because the criminal had an unconscious feeling of guilt stemming from other sources. He spoke of "*Verbrecher aus Schuldgefühl.*" In these cases the feeling of guilt was not the result of the criminal deed but the criminal deed was the result of the feeling of guilt.

No Punishment Prevents Crime

To sum up: No punishment prevents crime. Responsible for that fact, is the unconscious calculation on punishment in the criminal's deed. It is an integral part of the crime. The dread of punishment can therefore not prevent crime. Paradoxically—to quote an ironically-inclined patient of mine, a criminal lawyer—dread of punishment is more necessary for non-criminals than for criminals. The non-criminal needs unconscious recompense for being a life-long good boy. Therefore public opinion asks for severe punishment of criminals. The majority of habitual criminals are unchangeable. This is only a reminder to be less optimistic about the penal results—especially in the case of second and third offenders—and to have less illusions about persons having "learned their lessons." People in general, and criminals in particular, do not learn so easily.

Every society must protect itself against individuals who do not accept the rule of the community. Criminal deeds are outside the social game; they represent specific solutions of specific inner conflicts, and endanger the community as a whole. The habitual criminal himself has nothing to hope for from the solution of the enigma of crime. He will very likely be treated differently *morally;* he will be acknowledged to be a sick person. *De facto* he will pay for the omission of the moral odium with disadvantages: for instance, life-long detention. The moment the illusion of betterment and rehabilitation of habitual criminals through punishment is abandoned because it does not work, society will regretfully impose life-long detention on the habitual criminal, not because he is "bad" but because he is a danger to the community.

Whether psychiatric criminology will ever become a therapy, is a matter of conjecture.

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COMPARATIVE RESULTS OF ELECTRIC SHOCK AND METRAZOL TREATMENTS OF DEMENTIA PRAECOX*

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Metrazol has been used as a convulsive agent at Brooklyn State Hospital in the treatment of dementia præcox since 1937. In 1942 the use of electric shock as the convulsive agent was begun. Because of the relative ease with which electric shock can be administered there has been a tendency to discard metrazol. It is, therefore, indicated at this time that a comparison of the results obtained from the use of the two methods be made in order to determine whether this tendency is justified. This comparison is the purpose of this paper.

For this study a series of 502 dementia præcox patients has been reviewed, 249 of whom were treated with metrazol and 253 treated with electric shock during the period of April 1, 1944 to March 31, 1945. Standard methods of both metrazol and electric shock therapy were employed, and the cases treated were unselected except in regard to diagnosis of dementia præcox. The cases treated with metrazol will be discussed first.

Table 1 indicates the eventual distribution of metrazol-treated cases:

TABLE 1. METRAZOL. DISTRIBUTION OF CASES

Type of dementia præcox	Out of hospital			In hospital			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Catatonic	19	65	84	33	38	71	52	103	155
Paranoid	10	28	38	21	27	48	31	55	86
Hebephrenic	0	1	1	5	2	7	5	3	8
Total	29	94	123	59	67	126	88	161	249

Of the 249 patients treated with metrazol, 123, or 49 per cent, left the hospital. Of the catatonics, 54 per cent were out of the hospital; of the paranoids, 44 per cent; of the hebephrenics, 12 per cent. Many of these patients had received no previous shock therapy. The balance had. In order to determine if there were any differ-

*Read before The Brooklyn Neurological Society, at Brooklyn State Hospital, May 22, 1945.

ences in results the cases were separated into two groups: (a) those who had received no previous shock therapy, and (b) those who had.

Table 2 indicates the patients with no previous shock therapy who received metrazol.

TABLE 2. METRAZOL WITH NO PREVIOUS SHOCK THERAPY

Type of dementia præcox	Out of hospital			In hospital			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Catatonic	12	57	69	14	29	43	26	86	112
Paranoid	9	27	36	13	24	37	22	51	73
Hebephrenic	0	1	1	2	1	3	2	2	4
Total	21	85	106	29	54	83	50	139	189

Here one finds a total of 189 cases, 50 men and 139 women. Of the 189 cases treated, 106, or 55 per cent, left the hospital. Further analysis reveals that of the 50 men treated, 21, or 42 per cent, left the hospital; and of the 139 women, 85, or 61 per cent, left the hospital. From these figures, one would assume that better results were obtained in the treatment of female patients; but, in a subsequent table, it will be demonstrated that this is not so. Actually the male cases were of longer duration than the female.

Table 3 shows the results of metrazol treatment in dementia præcox patients who had received some form of shock therapy previously. The previous treatment may have been insulin, metrazol, electric shock or combinations thereof.

TABLE 3. METRAZOL AFTER PREVIOUS SHOCK THERAPY

Type of dementia præcox	Out of hospital			In hospital			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Catatonic	7	8	15	19	9	28	26	17	43
Paranoid	1	1	2	8	3	11	9	4	13
Hebephrenic	0	0	0	3	1	4	3	1	4
Total	8	9	17	30	13	43	38	22	60

Here we notice that of the 60 patients treated with metrazol following other shock therapies, 17, or 28 per cent, left the hospital. Of the 38 men treated, eight, or 21 per cent, left the hospital. Of 22 women, nine, or 40 per cent, left.

These two groups of metrazol-treated patients were reviewed with respect to the duration of symptoms prior to treatment. Tables 4 and 5 illustrate this.

Table 4 gives the duration of symptoms in those patients who had not received previous shock treatment:

TABLE 4. METRAZOL. DURATION OF SYMPTOMS PRIOR TO TREATMENT IN CASES WITH NO PREVIOUS SHOCK THERAPY

	Out of hospital			In hospital			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Up to 6 months	7	66	73	2	26	28	9	92	101
6 months to 2 years	7	13	20	9	17	26	16	30	46
Over 2 years	7	6	13	18	11	29	25	17	42
Total	21	85	106	29	54	83	50	139	189

From Table 4 one finds that of the 189 cases treated, 101 had durations of less than six months. Of these 101, 73, or 72 per cent, left the hospital. There were 46 patients whose durations of illness were from six months to two years. Of these, 20, or 43 per cent, left the hospital. In the group with durations of over two years there were 42 cases. Of these, 13, or 30 per cent, left the hospital. Analysis reveals that of nine males with symptoms of less than six months duration, seven, or 77 per cent, went home; of the 16 males of six months to two years duration, seven, or 43 per cent, went home; of the 25 males of over two years duration, seven, or 28 per cent, went home. Of the 92 women with symptoms of less than six months duration, 66, or 71 per cent, went home; of the 32 of six months to two years duration, 13, or 43 per cent, went home; of the 17 of over two years duration, six, or 34 per cent, went home.

From these figures one sees that there were nine males as compared to 92 females whose illness was of less than six months duration. This, then, explains the greater percentage of improvement in the women.

Table 5 indicates the duration of symptoms prior to treatment in cases of dementia præcox who had previous shock therapy:

TABLE 5. METRAZOL. DURATION OF SYMPTOMS PRIOR TO TREATMENT IN CASES WITH PREVIOUS SHOCK THERAPY

	Out of hospital			In hospital			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Up to 6 months	1	3	4	1	1	2	2	4	6
6 months to 2 years	2	4	6	11	7	18	13	11	24
Over 2 years	5	2	7	18	5	23	23	7	30
Total	8	9	17	30	13	43	38	22	60

It is to be noted that of the 60 cases treated, only six had been ill less than six months; 24 had been ill from six months to one year; and 30 had been ill over two years. Of the six with symptom durations of less than six months, four, or 66 per cent, left the hospital; of the 24 with durations of six months to two years, six, or 25 per cent, left the hospital; of the 30 with durations of over two years, seven, or 23 per cent, left the hospital.

Here, again, it is to be noted that the shorter the duration of illness, the better the results. One also notes that the results are actually poorer in these cases than in patients who received no previous shock therapy.

The group of dementia præcox patients treated with electric shock will be reviewed similarly.

Table 6 shows the eventual distribution of cases treated with electric shock:

TABLE 6. ELECTRIC SHOCK. DISTRIBUTION OF CASES

Type of dementia præcox	Out of hospital			In hospital			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Catatonic	29	22	51	49	33	82	78	55	133
Paranoid	19	20	39	42	23	65	61	43	104
Hebephrenic	4	1	5	6	5	11	10	6	16
Total	52	43	95	97	61	158	149	104	253

Of the 253 patients treated, 149 were men, and 104 women. Of the entire group, 95, or 37 per cent, left the hospital. Of the catatonic patients, 38 per cent were out of the hospital; of the paranoids, 37 per cent; and of the hebephrenics, 31 per cent.

Here, again, this group was separated into two subgroups (a) patients without previous shock treatment, and (b) patients with previous shock treatment.

Table 7 indicates the results of electric shock in cases with no previous shock treatment:

TABLE 7. ELECTRIC SHOCK WITH NO PREVIOUS SHOCK THERAPY

Type of dementia præcox	Out of hospital			In hospital			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Catatonic	18	22	40	27	18	45	45	40	85
Paranoid	16	16	32	25	18	43	41	34	75
Hebephrenic	2	1	3	3	1	4	5	2	7
Total	36	39	75	55	37	92	91	76	167

Of the 167 patients treated, 75, or 44 per cent, left the hospital; of the 91 males, 36, or 39 per cent, left; of the 76 females, 39, or 51 per cent, left.

Table 8 shows the results in patients who had received previous shock therapy.

TABLE 8. ELECTRIC SHOCK AFTER PREVIOUS SHOCK THERAPY

Type of dementia præcox	Out of hospital			In hospital			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Catatonic	11	0	11	22	15	37	33	15	48
Paranoid	3	4	7	17	5	22	20	9	29
Hebephrenic	2	0	2	3	4	7	5	4	9
Total	16	4	20	42	24	66	58	28	86

Of the 86 patients treated, 20, or 23 per cent, left the hospital; of the 58 males, 16, or 27 per cent, left; of the 28 women, four, or 14 per cent, left.

Table 9 gives the duration of symptoms prior to treatment in cases with no previous shock therapy.

TABLE 9. ELECTRIC SHOCK. DURATION OF SYMPTOMS PRIOR TO TREATMENT IN CASES WITH NO PREVIOUS SHOCK THERAPY

	Out of hospital			In hospital			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Up to 6 months	9	25	34	13	15	28	22	40	62
6 months to 2 years	8	10	18	11	13	24	19	23	42
Over 2 years	19	4	23	31	9	40	50	13	63
Total	36	39	75	55	37	92	91	76	167

Analysis reveals that of the 62 cases treated with less than six months duration, 34, or 54 per cent, went home; of the 42 with six months to two years duration, 18, or 42 per cent, went home; and of the 63 with over two years duration, 23, or 35 per cent, went home.

Of the 22 males of less than six months duration, nine, or 40 per cent, went home; of the 19 of six months to two years duration, eight, or 42 per cent, went home; of the 50 of more than two years duration, 19, or 38 per cent, went home.

Of the 40 women with less than six months duration, 25, or 62 per cent, went home; of the 23 with six months to two years duration, 10, or 43 per cent, went home; and of the 13 of over two years duration, four, or 30 per cent, went home.

Table 10 shows the duration of symptoms in electrically-treated patients who had had previous shock therapy.

TABLE 10. ELECTRIC SHOCK. DURATION OF SYMPTOMS PRIOR TO TREATMENT IN CASES WITH PREVIOUS SHOCK THERAPY

	Out of hospital			In hospital			Total		
	M.	F.	T.	M.	F.	T.	M.	F.	T.
Up to 6 months	2	1	3	5	1	6	7	2	9
6 months to 2 years	9	2	11	22	8	30	31	10	41
Over 2 years	5	1	6	15	15	30	20	16	36
Total	16	4	20	42	24	66	58	28	86

It is noted that of the 86 patients treated, only nine were ill less than six months; 41 were ill from six months to two years; 36 were ill over two years.

Of the nine with less than six months duration, three, or 33 per cent, went home; of the 41 cases with six months to two years duration, 11, or 26 per cent, went home; of the 36 cases over two years duration, six, or 16 per cent, went home.

COMPLICATIONS

In this series, there were no fractures encountered in the metrazol therapy. Two male patients suffered fractures of the humerus with electric shock treatment. It was the writers' feeling that the low incidence of fractures is due to the technique of hyperextension of the spine and the custom of avoiding the use of all restraint.

Summary

I. Four hundred and ninety-nine dementia præcox patients were treated with convulsive therapy. Two hundred and fifty-three were treated with electric shock; 249 with metrazol.

II. Of the 249 treated with metrazol, 123, or 49 per cent, left the hospital.

III. Of the 253 treated with electric shock, 95, or 37 per cent, left the hospital.

IV. Of the 189 treated with metrazol who had had no previous shock therapy, 106, or 56 per cent, left the hospital.

V. Of the 167 treated with electric shock who had had no previous shock treatment, 75, or 44 per cent, left the hospital.

VI. Of the 189 metrazol-treated patients with no previous shock therapy, 101 had had durations of illness of less than six months; 73, or 72 per cent of these, left the hospital.

VII. Of the 167 electrically-treated patients with no previous shock therapy, 62 had had durations of less than six months; 34, or 54 per cent, left the hospital.

VIII. Of the 60 patients treated with metrazol who had had previous shock therapy, 17, or 28 per cent, left the hospital.

IX. Of the 86 patients treated with electric shock who had had previous shock therapy, 20, or 23 per cent, left the hospital.

X. Of the 60 patients treated with metrazol who had had previous shock therapy, six patients had durations of less than six months; of these four, or 66 per cent, left the hospital.

XI. Of the 86 patients treated with electric shock who had had previous shock therapy, nine patients had had durations of illness of less than six months; of these, three, or 33 per cent, left the hospital.

XII. In patients who had received previous shock therapy with durations of over six months the results with either treatment are very similar.

Conclusions

I. From the results obtained from studies of the treatment of dementia præcox, metrazol is more effective than electric shock.

II. In patients who have had no previous shock therapy, metrazol is more effective than electric shock (55 per cent as compared to 44 per cent). Best results occurred in patients whose symptoms existed less than six months.

III. In patients who have had previous shock therapy, metrazol proved more effective than electric shock (28 per cent as compared to 23 per cent). The difference was greater with cases of less than six months duration (66 per cent as compared to 33 per cent). However, in cases whose symptoms existed for over six months the results were approximately the same.

IV. Metrazol is more effective than electric shock in the treatment of all types of dementia præcox, but predominantly so in catatonic dementia præcox.

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THE GRAPHIC RORSCHACH AS A SUPPLEMENT TO THE RORSCHACH IN THE DIAGNOSIS OF ORGANIC INTRACRANIAL LESIONS

BY JOSEPH R. GRASSI*

The Rorschach method has proved of invaluable aid in the clinical psychopathological field.[1] Before the advent of projective techniques, of which the Rorschach is one, there were no reliable diagnostic instruments available to the clinical psychologist. The so-called paper and pencil personality tests fell short of expectations and left much to be desired. The diagnostic tests which were available had not been sufficiently developed to give adequate and reliable evidence. Projective techniques are not entirely new in the field of clinical psychology, but they have been cautiously and slowly accepted. They were first regarded as intruders, in that they were different from the usual, accepted type of psychometric tests. Gradually, they have proved their value, and they are now recognized as outstanding, indispensable instruments of clinical psychology.

The Rorschach psychodiagnostic method is one of the best projective techniques. Extensive research in all the fields of applied psychology has established its value, but has not as yet exhausted its potentialities as a diagnostic instrument. Progress however, has been rapid and the results are inspiring. The Rorschach has elevated clinical psychology from the level of psychometry to a role of major importance in personality analysis.

In this paper, attention will be directed to a small, yet important aspect of the Rorschach, i. e., differential diagnosis of organic intracranial pathology. Rorschach patterns which are more or less characteristic for particular types of disease entities have been established. Search is continuing for features or elements which will provide even finer discrimination. Not all patients exhibit Rorschach patterns typical of their particular disease entities. Occasionally, a record may fail completely to indicate the patient's clinical syndrome. Kelley and Klopfer[2] state: ". . . all one may

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hope for is that a majority of patients showing the signs will be found to possess the disease entity in question, and conversely, that the majority of patients not suffering from the disease entity will not show the Rorschach responses." The range of failure is rather narrow, however, and further research may be expected to reduce it further.

Looking at the general Rorschach configurations of cerebral lesions, one may note first the findings of Harrower-Erickson.[3] The general picture is described as being restricted and constricted and usually showing the following signs:

(1) A poor output.

(2) AW to D to d to S proportion too heavily weighted with W, and lacking an adequate number of clear, precise forms.

(3) A percentage of F responses higher than normal.

(4) A poor range of psychic reactivity; a more constricted and uniform personality structure than normal (M: sum C barely 1:1).

(5) Absence of K and FK throughout.

Studies by others demonstrate that some of these signs occur in records of normals, depressives, and mental defectives.

Piotrowski[4, 5] has described 10 signs which, he feels, differentiate patients with cortical and subcortical brain pathology from other groups of patients. He concludes that if five or more of his signs are present the patient is undoubtedly suffering from brain damage. This conclusion has been found valid. However, when the minimum signs are absent, it does not hold true that the patient is undoubtedly *not suffering* from an organic brain condition. Piotrowski's 10 signs associated with intracranial lesions are as follows:

(1) R Number of responses is not more than 15.

(2) T Indicating an average time per response of more than one minute.

(3) M Indicating that the number of movement responses is no more than one.

(4) F+% Indicating that the percentage of good form responses is below 70.

(5) P Indicating that the percentage of popular responses is below 25.

(6) Cn Indicating that the record contains at least one color denomination. This is one of the most important signs.

(7) Rpt. Repetition or perseveration of the same response to several inkblots.

(8) Imp. Impotence indicates the giving of a response in spite of the recognition of its inadequacy.

(9) Plx. Perplexity is associated with a distrust of one's ability and a request for reassurance.

(10) Ap. Automatic phrases are scored when the patient uses a phrase in an indiscriminate fashion.

The material in Table 1 is a composite and condensation of the findings of numerous workers as published in current literature.

TABLE 1

R	Not more than 15 (reduced output in tumor cases).
T	Average time more than one minute per response.
M	Not more than one (may be more in paretic, post-traumatic, and encephalitic cases).
F%	F% below 70; F% 50-70 in encephalitis; poor form quality in tumor cases; large number of F with many F— in post-traumatic, cases; F% higher than normal in cases of brain tumor.
Cn	At least one color-naming. Some pure C if found in post-traumatic records and also color shock which may vary on re-testing.
M:sum C	Predominance of color in encephalitis; the tumor patient shows constriction with ratio barely 1:1.
Shading	Absence of K and FK in brain tumor; post-traumatic patients reveal shading shock only if the neurotic element is more pronounced than the organic. K and c are found and are almost pathognomonic if more than 3.
Refusal	Patient cannot do better "on request."
A%	Stereotypy, etc.
P%	Less than 25 per cent in records of less than 25 responses.
Repet.	Three similar responses within a record without regard for form. Encephalitic records show perseveration.
Imp.	Impotence.
Plx.	Perplexity.
Ap.	Use of automatic phrases.
Approach	The post-traumatic reveals many Dr. (10 per cent to 25 per cent slight, 26 per cent to 32 per cent moderate, over 50 per cent severe) or else has DW's. There is confabulation in encephalitis, also an occasional Do. In tumor cases there is an overemphasis of W (with poor F).

Success. There is disturbed succession in post-traumatics, also encephalities. Difficulty in relating concept to blot may be one of the few signs of frontal lobe lesion.

Re-test Post-traumatic color shock may vary. Organics cannot improve performance in the inquiry or testing of limits. This may be another of the few signs of frontal lobe lesion.

Although much progress has been made with the verbal Rorschach in establishing signs of organic damage, many patients with clinically demonstrable brain disease fail to show a sufficient number of signs to warrant such a diagnosis. The writer believes the Graphic Rorschach to be a valuable technique for bringing many of these cases into diagnostic range.

The Graphic Rorschach technique is described in previous publications,[6, 7, 8, 9, 10, 11] depicting its application to large unselected groups of subjects and patients. This technique is considered to be a supplement to the verbal Rorschach. It is usually administered at the conclusion of the verbal Rorschach inquiry. However, the graphic may be deferred until a later date, if necessary. At the conclusion of the verbal inquiry, with the cards shown in the usual order, specific instructions are given to draw from each card, the impression which the subject has just described. He receives freedom to omit, alter, or add to the features of the blot. At the completion of the drawing, the subject is asked to point out the relation between his drawing and the blot.

The drawings are then rated and scored, according to the established criteria. Drawings will range from extreme blot-copy to those which are unrelated initially to the blot form. A parallel continuum from the former type of drawing to the latter is noted. The blot-copy type of performance is designated as a "blot-dominated" response; the other type as "concept-dominated."

The scoring criteria for the five fields of variability have been established as follows:

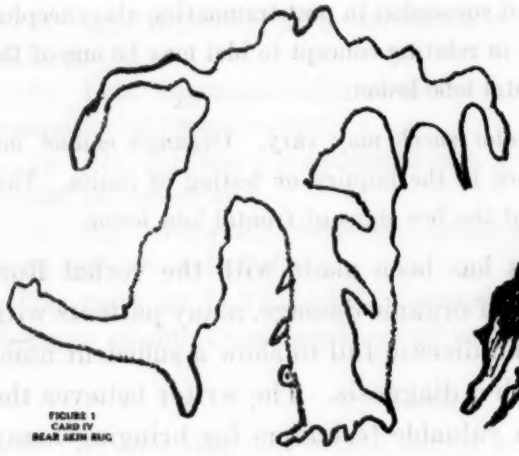

FIGURE 1
CARD IV
BEAR SKIN RUG

FIGURE 4
CARD V
INSECT

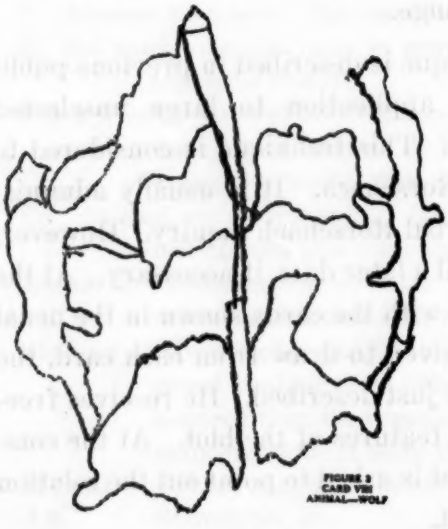

FIGURE 2
CARD VIII
ANIMAL—WOLF

FIGURE 5

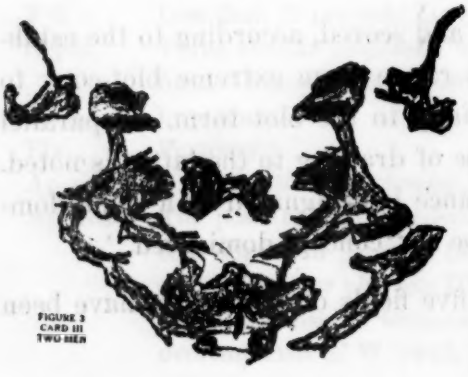

FIGURE 3
CARD III
TWO MEN

FIGURE 6

Scale One

ELABORATION: (Treatment of particular area selected for interpretation.)

1. *All* details of the area selected are included in the drawing whether relevant or irrelevant to the response.
2. *Some* details irrelevant to the response are included in the drawing.
3. Only details relevant to the response are included in the drawing.
4. *Some* details relevant to the response are omitted.
5. *Extreme* disregard for blot details.

Scale Two

ORGANIZATION: (Relationship between area selected for interpretation and adjacent areas of the blot.)

1. Includes in the drawing, *all* irrelevant adjacent areas of the blot. (Indiscriminate use of blot areas to include every area of the card.)
2. Includes in the drawing, *several* unrelated adjacent areas of the blot. (False unity.)
3. Includes in the drawing only areas relevant to the interpretation.
4. Use of detail to give meaning to the whole.
5. Excludes in the drawing, so *many* blot areas relevant to the interpretation that the drawing resembles response but not blot.

Scale Three

ACCURACY: (Modification of the shape of the blot features.)

1. *Complete* absence of modification of any blot features.
2. Some *minor* modifications of the gross form of the blot.
3. Modifications to enhance the interpretation.
4. Presence of modification, severely altering blot features.
5. *Excessive* modification with total loss of relationship between blot and drawing. Drawing has no resemblance to the blot producing the response.

Scale Four

COLOR: (Use of the color of the blot.)

1. *Exact* color matching of the colors of the blot. (Hue matchings.)
2. Matching color of the blot but *not* the *hue*.
3. Use of color in the drawing, if color is relevant to the response.
4. *Failure* to use color in a color-determined response.
5. Introduction of color not present in the blot.

Scale Five

ELASTICITY: (Inclusion of details not suggested by the blot features.)

1. *Complete* absence, in the drawing, of additional details pertinent to the interpretation.
2. *Absence* of supplementary additions to enhance the interpretation.
3. Spontaneous relevant additions to supplement or enhance the drawing.
4. Inclusions in the drawing, some additions irrelevant to the form of the blot.
5. Inclusion in the drawing of many irrelevant additional details, sacrificing the blot form so that inkblot bears no resemblance to the interpretation.

Diagnostic criteria for the various clinical groups have been established. We shall primarily concern ourselves here with the criteria set forth for organic involvement.

The method of scoring and interpreting Graphic Rorschach productions has been described in several publications. A complete and full picture of the patient's graphic can best be obtained by using the method outlined. However, an inspection method is now offered which has proved itself reliable in the majority of cases. Where the inspection method fails, the regular scoring and interpretative procedure should be employed. The short method does not necessitate any scoring or plotting of deviations, charts, or graphs. However, it does take into consideration the subject's behavior during the administration of the graphic, in addition to inspection-scoring of the drawings. Ten signs have been found to be significant of an organic graphic production. These signs are listed in the order of their importance. If five or more signs are present in a record, including some of the more important ones, the diagnosis of organic intracranial lesion is justified. If less than five signs are present, but among them are *three* of the most important signs, a diagnosis is again justified. The signs are enumerated as follows:

1. ***Excessive drawing time.*** Almost all drawings take five minutes or more.

2. *Extreme blot-dominance.* The patient attempts to copy all the elements of the blot, relevant and irrelevant. There is an uncontrolled drive toward precise reproduction as reflected in the patient's desire to copy every tiny detail, suggesting inability to discriminate between essential and non-essential elements.

3. *Spatial disorientation.* The final production is distorted and symmetry is completely lacking. Organization of the whole is lost.

4. *Color matching.* The patient attempts to match the exact colors of the card whether relevant to the concept or not. In extreme cases the matching is carried as far as the hue.

5. *Verbal commentary.* Rationalization on the part of the patient to excuse inclusion of irrelevant areas. The patient justifies his production with rationalizations, rather than realizes the inadequacies present in his drawing. There is personal satisfaction with the production.

6. *Complete absence of additional details pertinent to the interpretation.* The patient cannot make any additions to enhance his drawing because of lack of ability to put concept into concrete form.

7. *Modifications are completely absent.* The patient is unable to modify any features of the blot.

8. *Skipping.* The patient becomes so engrossed in each detail that he jumps or skips from one section of his drawing to another. As a result, each previous section is left unfinished.

9. *Co-operation during the entire procedure is excellent.* The patient enjoys his task and would continue for hours if permitted to do so.

10. *Graphic perseveration.* (Important signs.) Graphic organic vs. graphic non-organic.

It is interesting to note the number of Graphic Rorschach signs which are similar to those set forth by Piotrowski:

Piotrowski	*Graphic*
(1) Increased reaction time.	(1) Excessive drawing time.
(2) Color naming.	(2) Color matching.
(3) Impotence.	(3) Rationalization for inclusion of irrelevant areas.
(4) Good form percentage low.	(4) Extreme blot-dominance.
(5) Automatic phrases.	(5) Content of verbal commentary.
(6) Perseveration of responses.	(6) Graphic perseveration.

Disagreement with the Piotrowski signs is at a minimum. Some of his signs are not applicable to the graphic examination. The

number of responses is dependent upon the verbal Rorschach in that the drawings are made according to the responses given during the Rorschach proper. Movement responses cannot be measured by the graphic test. Consequently, no marked disagreement between the two sets of signs exists. The remaining Piotrowski signs—perplexity, repetition, and popular responses—deviate somewhat from the graphic signs in that the graphic approach produces a different type of situation for the patient. Perplexity is not clearly demonstrated in the graphic test. The patients are pleased with their productions and as a rule do not look for reassurance from the examiner. They seem to feel that their productions are adequate, and need for help is not necessary. Repetition, *per se,* is absent. Each blot produces a different drawing. However, repetition is present in terms of the patient's behavior. He repeats the same performance for each blot. Each inkblot brings forth perseveration of the thought-processes. Therefore, in terms of the patient's manner of representing his percepts, perseveration is definitely indicated. Popular responses are not measurable by the graphic method for obvious reasons. Those responses which would be at the popular level verbally may be so contaminated by the patient's blot-dominated, perseverative production that they could not be considered popular-level percepts despite the patient's verbal assignment of a popular name to them. The graphic production may indicate that the patient is not clearly perceiving the response at the so-called popular level. For a description of finer discrimination of form level, see: "Clarification of Rorschach responses by the Graphic Rorschach."[8]

In all, therefore, one finds six Piotrowski signs closely associated with graphic signs. It is interesting to note that the most important organic signs are present in both verbal and graphic responses. Disagreement is present in one case only. Two other signs are closely associated but measure the patient's behavior from different aspects, although they arrive at the same conclusions.

The following records of patients with positive clinical and laboratory signs of intracranial pathology are offered for discussion:

CASE 1

Verbal Rorschach

Subject: E. Q. Age: 29. Male. (Psychosis with brain tumor.)
February 24, 1945.

			Performance	*Inquiry*
I.	1.	15″	A crab.	Whole card.
	2.		Beetle.	Middle section.
	3.	30″	A spider crossed on a web.	Waiting to move.
II.	1.	5″	Two men playing a game; odd creatures.	
			Fancy hair-do.	
			Like old women clapping hands.	
		45″	Kicking feet together.	
III.	1.	10″	A couple of jitterbugs about to bob for apples.	
			Or Hallowe'en setting.	
		30″	Holding a jug.	
IV.	1.	10″	Bear skin rug.	Shape of head.
			Feet spread. Bit of body.	Coloring, shading as if hunter.
			Wrong end.	
	2.		Bulky men walking with extra large feet.	Walking away.
				Shoulder, leg, thick body.
				Shadings for eyes, nose.
	3.		Face of dog, eyes.	
			Long slender nose.	
	4.		Surrealist painting.	
	5.		Interior, face in shadows; eyes, only dead expression.	
	6.		On other side, another face.	Long angular face, wrinkles by shading; outside detail.
			Gray streak; forehead.	
	7.		Dog here, laying down.	
	8.	120″	Face of a bull.	
V.	1.	20″	Odd shaped butterfly wounded, pulled apart.	Stretched out of shape; dead.
		60″	Antenna; an insect "eerie—evil."	

VI.	1.	5″	Pelt of small animal stretched out for drying.	Inside because of shading.
	2.		Unusual design as in wood, dark center.	Wood burned.
	3.	60″	Parasite magnified many times.	Upper center.
VII.	1.	10″	A pair of book-ends with caricatured creature.	
	2.		Mamie Yokum with extra-large developed head.	
	3.		Book-ends pushed together to pose for picture. Plume sticking up,	
		45″	very delicate.	
VIII.	1.	10″	Diagram from hygiene book. Tissues.	Abdomen opened up — lacy bone running down center.
	2.		Animal—wolf, stepping from one stone to another with reflection in water hungry-snarling.	Something draining into bowl.
	3.		Vegetation on sea bottom, lacy	
		180″	edges, half shell with moss.	Color for moss too.
IX.	1.	15″	Baby on the bottom having a bad dream.	
	2.		Two witches on top extending hands.	
	3.		Two more witches riding broom.	
	4.		Old women doing work at a bench.	Green.
	5.	120″	Face of Grover Cleveland.	
X.	1.	10″	Drunk's night-mare. Serpent, two necks, one head. Goldfish with feet, two crabs walking around. Wishbone in center. Two potatoes, eyes starting to sprout extra lines—setting made up for an entrance.	(Brown sides.)
	2.		Sea horses, green top.	
	3.		Piece of watermelon, shredded	(Red.)
		75″	thin.	

This record does not contain a sufficient number of organic signs to warrant a verbal Rorschach diagnosis of organic pathology. Two Graphic Rorschach productions, typical of all the patient's drawings are illustrated. (See figures 1 and 2.)

The drawings contained the following Graphic Rorschach signs of organic pathology: (1) Excessive drawing time; (2) verbal commentary; (3) complete lack of additions; (4) complete absence of modifications; (5) extreme blot-dominance; (6) co-operation; and (7) graphic performance perseveration.

Case 2

Verbal Rorschach

Subject: B. J. Age: 50. Male. (Psychosis with Syphilis of C. N. S.) March 31, 1945.

Performance				*Inquiry*
I.	1.	10″	Man with cape on.	Upper sides, alive.
	2.	45″	Woman—veiled with hands sticking up.	(Center section.)
II.	1.	5″ 15″	Two men kneeling down heads out of view, hands joined.	(All of black)
III.	1.	5″ 15″	Two men, two society gentlemen, have experienced unfortunate events, are trying to pull something apart. Clothes tattered.	
IV.	1.	5″	Hideous monster, undersea animal.	Head only (lower center.)
V.	1.	5″	Insect of some sort.	Whole thing, alive.
VI.	1.	10″	Bear rug spread out on the floor.	Because its spread out.
VII.	1.	10″	Two old ladies bobbed head. Making faces at each other, clothes being blown around by the wind.	
VIII.	1.	5″	Skeleton of some sort of animal.	Whole card except animals, crab shell, fish, also color.
	2.		Wolves walking; traversing country.	

IX.	1.	10″	Rolled-up hams.	Color, shape, left green.
	2.	20″	Old fuzzy man.	Crawling, trying to get away.
X.	1.	15″	Goodness! Undersea life. Several kinds to bottom of ocean.	Bottom green.
	2.		Eels.	Yellow lower center.
	3.		Skate.	Blue outside.
	4.		Crabs.	Making faces at each other.
	5.	40″	Catfish.	Upper center.

The second record is similar to the first in that the verbal record fails to reveal organic signs. The graphic productions (see figures 3 and 4) however, contained the same organic indicators as the first, in addition to color matching. On the basis of the number of Graphic Rorschach signs a diagnosis of organic intracranial pathology appeared justified. This impression was substantiated by the results of other psychological tests as well as by clinical and laboratory findings.

Illustrative drawings of normals, psychotics, psychoneurotics, manics, depressives and organics are depicted in the "Graphic Rorschach Manual."[5] However, two typical, normal graphic responses are repeated to demonstrate the qualitative and quantitative differences between a normal production and an organic representation. In Figures 5 and 6, the drawings are characterized by the use of both blot and concept elements. There is a compromise between use of the blot features and concept elements. Consequently, the patient's final production resembles the blot which brought forth the response and also the patient's concept. A normal production exhibits close agreement among the drawing, the inkblot features, and the subject's concept. The organic patient, on the other hand, cannot utilize any elements of the concept—conceptual thinking may be present, but there is little, if any ability to use it.

In the Graphic Rorschach, perseveration may be revealed in two diametrically opposed manners; blot-dominated and concept-dominated perseveration. In the latter, all graphic productions are identical regardless of the blot features. There may be little, if any, resemblance between the drawing and the blot. The drawings represent the patient's concept only—with little regard shown for the features of the blot. This type of perseveration is similar to that described for the verbal Rorschach. It does not necessarily follow, however, that when perseveration is present in the verbal Rorschach it will be found in the graphic productions in the concept-dominated form. It may take either a blot-dominated or concept-dominated form, depending on the type of mental activity the patient has at his disposal. In the former, there is a perseveration of performance, in contrast to the latter, which may be considered an activity or verbal perseveration. The blot-dominated perseveration results in as nearly an exact copy of the inkblot as the patient can produce. The patient perseverates in performance in that he does the same thing with each blot, that is, he copies all details whether relevant or irrelevant to the response. He begins with a particular type of performance and cannot alter or change his course during the rest of the test situation. His inability to shift from one aspect of performance to another is similar to that demonstrated by organic patients when performing with the so-called organic tests for the determination of impairment of abstract organization.

Obviously, organic patients exhibit the blot-dominated type of perseveration. Their blot-dominance is of a severe nature in contrast to certain types of deteriorated schizophrenics, who show blot-dominance perseveration to a moderate degree. In passing, one may remark on a second group of schizophrenics, who show the concept-dominated type of perseveration. It would appear that the concept-dominated schizophrenics would fall into the category of good prognosis, whereas the blot-dominated group would be classified with those less likely to improve. The reason for this is obvious.

Summary and Conclusions

1. The use of the Graphic Rorschach as a supplementary instrument to the orthodox verbal Rorschach examination in the diagnosis of intracranial lesions is described.

2. Ten graphic signs recognized by inspection are offered for the graphic interpretation of productions by organic patients.

3. The relationship between Piotrowski's organic signs and those of the graphic is pointed out. Agreement is significantly close.

4. Two Rorschach records and four drawings of organic patients are discussed. (Figures 1, 2, 3, 4.)

5. Verbal and performance perseveration are discussed as types of mental approach found in various clinical entities. On the Graphic Rorschach they are termed concept-dominated and blot-dominated perseveration.

6. Prognostic implications of graphic perseveration are suggested.

7. Use of both the verbal Rorschach and the Graphic Rorschach will aid in the diagnosis of many organic cases in whom the diagnosis is not well defined by the verbal Rorschach alone.

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CONVERSION HYSTERIA IN A 10-YEAR-OLD BOY

Report of a Case

BY E. R. CLARDY, M. D.

A research project on the study and treatment of certain types of behavior problems and psychoses in children was begun in 1939 at the Rockland State Hospital Children's Group. The present case of conversion hysteria in a 10-year-old boy was included in that project.

According to Kanner,[1] "hysterical attacks, which seem to have been rather frequent in former centuries, are very unusual in our time and environment. There are busy psychiatrists and pediatricians who confess to having witnessed but very few in the many years of their experience."

Charcot, Mesmer, Janet[2] and others described hysterical attacks which often resembled epilepsy. "Generally the patient chooses a spot to fall in such a way as not to hurt himself. The whole body becomes rigid and arched backward, the limbs extended, the eyes roll upward, and the lids and jaws tightly close. Sometimes there is cyanosis and temporary cessation of breathing. There is a state of peculiar postures and grimaces, various forms of awkward rotating, kicking and incoordinate movements ('clownism'). The attack ceases after a few moments, with no biting of tongue and no loss of sphincter control."

The following case presents almost an exact replica of the symptoms described by these authors.

Case Report

Harold S., a 10-year-old boy of German and Swedish ancestry, complained of pains all over his body associated with shaking spells.

The remote family history appeared to reveal nothing of importance. The mother was described as an intelligent individual who completed the third year of high school, worked as a milliner and also took up stenography. She is a person of good standing and has served as special deputy sheriff and court officer. At the age of 23 she married Mr. S., who was three years younger than

she. At the time of her marriage she was three months pregnant but described this situation as merely coincidental for she had been going with Mr. S. for several years and they really intended to marry. The husband was a hard worker and had many friends. He was a "devil-may-care, easy-going, happy man before his accident."

It appears that in December 1931, he was in a severe automobile accident. He was thrown several feet, struck his head on the sidewalk, and was unconscious for about 14 days. He had sustained a basal skull fracture with concussion. When he returned home he had momentary attacks of unconsciousness, alternating with more severe spells, during which there was a generalized shaking of his extremities, described as convulsions. His personality changed, he drank to excess and "he was crazy and ready to fight anybody." Inasmuch as he became actually psychotic, he was committed to Binghamton State Hospital.

Harold, according to the history obtained from the mother, was an unplanned-for but not unwanted child. He was a full term baby. His birth and early development were normal. During childhood he suffered a number of illnesses—measles, whooping cough, mumps, scarlet fever, pneumonia and tuberculous glands of the neck. However, there was no evidence of any sequela affecting the central nervous system and he had no convulsions. His school life was uneventful; the quality of his school work was good; however, he never played very well with other children. He had been promoted to the seventh grade at the time of his admission to the Children's Group.

Although in school Harold had been described as somewhat seclusive and "a sissy," he was not a serious problem until December 1938, when, following an attack of pain in the right lower quadrant, he "doubled up and began to shake all over." A doctor was called; and it was said that the boy had acute appendicitis, but the attack subsided after a few hours. Thereafter, he suffered similar attacks almost daily and frequently had trembling spells. The condition became so severe that he was sent to a general hospital where he remained for eight days. At the end of that period Harold's mother was told there was nothing much wrong with the child, that his difficulties were "caused by masturbation" and that

he should be taken to a farm where he could receive "plenty of fresh air which would cure his trouble." This explanation seemed more foolish than ever to the mother, inasmuch as she had never known him to masturbate. Then he was sent to a child guidance clinic where it was advised that he was in need of more intensive psychiatric treatment. His case was therefore referred to Rockland State Hospital, where on January 27, 1940, at the age of 12 years he was admitted to the Children's Group.

The physical examination report described the boy as a well-developed and well-nourished individual. Examination of heart, lungs and abdomen was negative. The eye examination showed an old scar on the right cornea which was apparently the result of trauma. Otherwise, the eyes were normal.

A careful neurological examination was performed by an experienced neurologist. He described bizarre, patternless movements of head and limbs. Right and left patellar reflexes were absent, but this was not considered significant in view of the fact that the boy did not have any other definite neurological signs. Consequently, the neurologist's opinion was that Harold had no organic neurological condition. The electroencephalograph was normal.

The laboratory examinations revealed nothing of significance.

During the initial interview, a short time following admission, Harold displayed some twitches and other abnormal involuntary movements of gross irregular types, but they did not suggest any organic pattern. Most of these movements were classified as "startle movements" such as sudden jerking and twisting of the head accompanied by a distressed expression of the face. He smiled frequently. Occasionally he grimaced, stuck out his tongue and bit his upper lip. He denied that he feared his father, but admitted occasional fears that his father would have convulsions. He said that he had enjoyed school until recently when he became too nervous to do any work. Furthermore, he did not mix well with other boys at school. They called him "a sissy" because he never participated in their games. There was no evidence of delusions, hallucinations or other such major psychiatric manifestations. However, his emotional responses indicated an underlying tension and anxiety. He admitted that he daydreamed and fantasied a great deal. Upon psychometric examination, he was adjudged of

superior intelligence. Although the Stanford-Binet, Form L, gave him an I. Q. of only 108, it was felt that his disturbed emotional state lowered his score.

Two days following his admission an attendant came upon Harold while he was drinking a cup of water. His actions appeared normal until he saw this attendant when his arms and legs began to twitch. He became upset and cried for several minutes. About five days later he had another spell and was examined at that time by a neurologist who made the following statement, "He was having twitching movements of an irregular patternless type, grimaces of the face, sudden 'startle' movement, clenching and unclenching of the hands, and rhythmic flexion and extension of the lower extremities. There was no loss of consciousness. Although the child was crying he did not appear to be extremely upset." The neurologist thought that the entire picture was obviously of a psychogenic nature. The physician then ordered that the child have 10 grains of soda bicarbonate which had an *immediate quieting effect.*

During the next few weeks Harold was more or less a "lone wolf." He did not join in play with the other children. He became increasingly effeminate; he was fearful and constantly complained of somatic distress such as pains in his lower right abdomen. He did not care to venture outside his cottage unless an employee would go with him. He sought attention constantly. He slept poorly and was a "picky" eater.

Harold had numerous psychiatric interviews during which much interesting material was obtained. Once he dreamed he had contracted pneumonia and all the other sicknesses from which he had suffered during early childhood. He dreamed that his breath became short and that he died. The boy also complained of many psychoneurotic symptoms. He said that he had tried to belch and "a bubble stuck" in his throat. He said he twitched particularly when he was homesick and that was why he had these attacks at the hospital. After a few weeks of interviews the child began to speak of his father. He knew all the details of his father's illness. It was apparent that he was sensitive, fearful and at the same time resentful toward his father. He revealed that other children had teased him and called his father "crazy." He related dreams in

which his fear of the father was clearly expressed. He declared he was afraid that during convulsions the father might injure Mrs. S. He had dreams in which he himself had convulsive seizures; his aunt, uncles and grandparents would group around and bring him presents. The psychiatrist interpreted to him that perhaps he would like to take "spells" similar to those of his father and thus receive the undivided attention of his mother and other members of the family.

Harold improved rapidly a few months after the beginning of psychiatric interviews. His twitching spells and pains disappeared completely. He looked back on his symptoms as "foolishness" and in some way related to his reaction to his father. In June 1940 the boy's father died during a convulsive seizure. When the news was imparted to Harold he cried for a short time but said he supposed it was for the best and there was no use crying. Then he wrote a letter of consolation to his mother in which he reassured her concerning his reaction to his father's death. Immediately following that event, the boy began to masturbate and the twitching reappeared for a short time; and then both symptoms completely disappeared. In June 1941 following a 16-month period of tri-weekly psychiatric interviews, Harold had practically recovered from his conversion symptoms and was discharged to his mother. Also, according to recent information received, his good adjustment has been sustained.

Discussion

From the symptoms presented in the history, it appears that this child's hysterical reaction arose from the desire to obtain affection and attention from his mother. He had been the center of attention for years, then his father met with an accident and developed severe convulsive seizures. Consequently, a considerable amount of attention and care which had formerly been given to Harold was now directed toward Mr. S. Furthermore, the child frequently witnessed the father's violent seizures and was terrified by them. It also may be that these seizures signified to him a threat to his mother's happiness and safety. As a further result of having witnessed his father's seizures it may have caused him to develop a reaction of "*folie à deux.*" In addition to this

factor, the hysterical reaction appeared to follow temporary rejection by a paternal aunt to whom the boy was very much attached. It seems that he often slept in the same bed with this aunt and apparently had made an identification with her. This identification probably accounted to some extent for his effeminate appearance.

Summary

1. A typical case of psychoneurosis, conversion hysteria, affecting a 10-year-old child, was presented.

2. According to the literature, the occurrence of psychoneuroses in children is comparatively rare.

3. A successful termination of the case was brought about by a 16-month period of intensive psychiatric interviews.

Rockland State Hospital
Rockland N. Y.

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EDITORIAL

DAMNATION BY INFERENCE

Damnation by inference is not so different from damnation by faint praise, although it may be somewhat more effective. A current report, "Some Aspects of the Problem of the New York State Mental Hospital System," by E. H. L. Corwin, Ph.D., and Thelma Pierce, in the March 1, 1948 issue of the *New York State Journal of Medicine,* is as effective a job of damning the New York State Department of Mental Hygiene by inference as we ever hope to see. Presented, in their official journal, to the medical practitioners of New York State, this extraordinary rag hash of good sense and bad inference is likely to do as much harm as the sort of article addressed to the general public by Albert Q. Maisel, "Bedlam 1946," in *Life* two years ago.

Such a thing as this Corwin and Pierce report is particularly damaging because it is a report of a "survey," and the report of a survey supposedly made under responsible auspices and by competent investigators. Many of the recommendations proposed are excellent but the authors have neglected to note that most of those which are practical have long been urged by the state mental hospital authorities themselves. A considerable number relate to matters which are already in the process of being remedied. If the investigators were aware of current Department of Mental Hygiene activities, failure to mention them is inexcusable. If they were not aware of them they failed inexcusably to conduct a complete investigation.

Without support, a bald statement stands in the report ". . . because there is a lack of proper planning and organization. . ." We ask that this serious charge be explained and documented.

One may also note at the outset their comment: "It is regrettable that the experience with shock therapy is not being systematically and completely reported. In addition, research in the biologic, physiologic, endocrinologic and psychologic phases of dementia præcox is urgently needed." The most cursory inquiry should have disclosed that shock treatment records are both systematically and completely reported and that over a year ago a manual on shock therapy procedures was promulgated and put into use after considerable study by a departmental standing committee. In fairness, it may be added that for several years the department has been wrestling with the problem of controlled investigation of shock therapy. However, to date, it has been felt that any patient requiring shock therapy should have it—disregarding the apparent need for

untreated controls. Later reference in the report to the need for the use of modern methods of treatment in state hospitals might have included the statement that most practitioners in private practice or in licensed and veterans' institutions in this state received their training in both insulin and electric shock therapy at the institutions of the Department of Mental Hygiene. As for research in dementia præcox, the authors had only to look at the record of the extensive work which has been carried on for years at the New York State Psychiatric Institute, to see the complete lack of justification for any inference that this problem was being neglected.

The investigators were impressed with the problem of overcrowding. They note that: "Most alcoholic patients. . .do not require the type of care which the state mtntal hospital can give. Save for an alcoholic psychosis, their mental derangement is of a temporary nature." The inference is that our state hospitals contain large numbers of non-psychotic alcoholics. Reference to the statute should have disabused the inquirers of this impression. According to the law, alcoholics can be admitted to state hospitals only when psychotic. It is quite true that they may be retained for a period after the subsidence of the psychotic episode for further therapy, having in mind the psychological basis of the alcoholism. Also, as every psychiatrist knows, the patient who was first diagnosed as alcoholic may have been discovered to be drunk because he was psychotic or neurotic—not psychotic because he was drunk. The general inference that the state hospitals contain large numbers of alcoholics without psychiatric disabilities cannot be justified. The same comment applies to the statement made to the effect that aged persons with minor mental symptoms are being sent into mental hospitals. Any valid criticism should have been directed at the petitioners, examining physicians and the judges responsible under the law for such certifications. In all equity the taxpayer who becomes psychotic as a result of senile or arteriosclerotic changes is just as much entitled to state hospital care as he who becomes ill as a result of dementia præcox. Further, it may be added that, after due thought and planning, a separate unit for the aged will be in operation at one of the hospitals during May 1948 upon a trial basis, and that at the others there are buildings or wards set aside for this group.

With further reference to overcrowding we are skeptical of the contribution to be made by proposed teams of outside psychiatrists in the reclassification of patients. Their office practice provides little relevant experience. It is not news that state hospital staffs were reduced during the war years—so were the staffs of general and private hospitals of all types. Few still have enough psychiatrists to do all that needs doing.

That the state hospitals have active consulting staffs in the various specialties, that the county medical societies meet regularly at some of the hospitals, that state hospital physicians teach at medical schools and are members of general hospital staffs in their communities seem also to have been unknown to the committee sponsoring this report.

Dr. Corwin and Thelma Pierce have made similar inferences which are not true concerning many other matters. They declare, for instance, that the low salaries paid by the state hospitals make it impossible to attract attendants of a caliber able to contribute to a constructive recovery program. Obviously these researchers are simply ignorant of the present favorable recruitment situation, the special provision relative to probation, the intensive training program and the provision in the present budget for new jobs in most categories. The New York State Salary Standardization Board has made public, and will make available to anyone interested, precise data upon salaries of comparable positions within the state government, in private agencies and hospitals and in a variety of other jurisdictions. That the salary picture in this department is favorable can easily be demonstrated to anyone who will take the time to verify the facts. The report is also incorrect in its statement that maintenance forms a part of salary.

Incidentally, contrary to another assertion in the report, the strong complement of social worker positions at each of the institutions has been publicly commended by a nationally-known figure in the field.

There is another very loose statement concerning the conditions of the present New York State hospital physical plants. "Some of the mental hospitals in New York State are over a hundred years old. They were built in the days when the care of mentally-ill persons was still not far removed from that accorded to criminals, and many still retain much of the atmosphere of the jail." Exactly *one* of the New York State hospitals is "over a hundred years old," although there may be some ancient buildings in some of the institutions taken over by the state many years later. Utica State Hospital was opened in 1843. Its original building is still in use but it has been remodeled and modernized; and most of the Utica plant is still far from reaching the century mark. Final plans are in process of completion and funds have been appropriated in the amount of sixty-eight million dollars as a start on the state's post-war reconstruction program for the mental institutions. This planning has been well publicized and we are at a loss to understand the failure of our critics to mention it.

Here are some other facts in this connection: Appropriations for rehabilitation last year amounted to almost two and one-half million dollars. A thorough-going study of maintenance needs and personnel was begun al-

most a year ago. During the last two fiscal years, better than one-half million dollars was spent in replacing and obtaining additional equipment. (It is still difficult of procurement.) For investigators who think these institutions—in need of improvements as they may be—resemble jails, we can only recommend that they pay a few visits to selected jails. The insult is, to say the least, gratuitous.

Admitting units are said to be necessary in the report. Let the investigators compare the admission facilities at a dozen of our institutions say, with those of some private hospitals we know and then draw conclusions.

The department, the physicians of the state, and the public at large require explanation of the following extraordinary statements appearing without supporting evidence in the text of the article:

> "At no time should a patient remain in a mental hospital because of the contribution he may make to any service of the institution.
>
> "Care should be taken, however, to assure that no patient is discharged before his condition warrants, regardless of the ability of his family to pay for him. Conversely, no patient should remain in the institution because a family is able to pay the maximum rate demanded.
>
> "His [the patient's] name is frequently unknown even to the nurse on his ward."

The *State Journal of Medicine* writers also have something to say about our financial methods. They cite the report of a 1944 commission that the methods employed in the collection of payments from relatives of patients are inadequate. Here there is much whipping of a dead horse. Collection methods, as the investigators should have learned, have been radically revised. The powers of our special agents to administer oaths, take testimony, subpoena and compel the attendance of witnesses and the production of books and records, are extraordinary. They have been in full use in recent years and the success of reimbursement endeavors deserves recognition. Precise figures appear in official public documents. In this connection, it is a naïve conclusion by the investigators that funds received for maintenance of patients pass into the hands of the department concerned. They do not—by law.

The report also notes that: "Low salaries, unsuitable housing, and the poor quality of the food make state mental hospital work unattractive to ambitious and alert psychiatrists." Salaries have been materially improved in recent years; housing at the majority of our institutions is better than that now generally available. There are exceptions but the criticism cannot apply to the state hospital system as a whole. And, as a mat-

ter of fact, funds for construction and final plans are presently at hand for the first installment of 62 single staff dwellings, in a project to better institutional housing for physicians. Neither can the food be justly criticized. In any large group of institutions some dietitians will prepare and serve food more attractively than others, but the quality in all is high and the allowances ample. It is a matter which could easily have been ascertained by any real investigation. Leaving out material things for the moment, it is believed that the Corwin-Pierce report in all fairness, should have cited the training programs inaugurated by this department, in the discussion of factors allegedly deterring young physicians from entering state service. For years staff physicians from all of the institutions have been sent to the graduate course in neuropsychiatry at Columbia University. Some two years ago the department inaugurated a systematic course for residents in basic neuroanatomy, neurophysiology, neuropathology and clinical neuropsychiatry. This has been supplemented by a course for clinical directors at the Psychiatric Institute, and by one in administrative psychiatry.

There are other unjustified inferences to the discredit of the Department of Mental Hygiene in the Corwin and Pierce article. The writers call, for instance, for the establishment "of adequate clinics for out-patient care throughout the state." This is a development we all desire but the authors do not define the word "adequate." Neither do they mention that there is already an extensive clinic system operated by the individual hospitals and by a bureau of the state department itself. The uninformed reader of the *New York State Journal of Medicine* could only conclude that we provide at the present time few or no clinics at all. Reference to the directory of our clinics would have prevented this error.

Similarly, the report recommends that "affiliation should be arranged with general hospitals to provide psychiatric training for all student nurses. . . ." It neglects to mention that provision for such affiliation for 88 general hospitals, including six out-of-state hospitals in 1947, has been in vogue for a good number of years. Thus, of 104 approved general hospital schools in this state, 82 send their students to state hospitals and, of course, a number of others utilize hospitals elsewhere.

The Corwin and Pierce report was drawn up under the guidance of a subcommittee of five members of the committee on public health relations of the New York Academy of Medicine. Two of the five subcommittee members are psychiatrists and one a neurologist; and there is no disposition to suppose that any of the five or their two investigators had anything but the friendliest feelings toward our mental hospitals or any other intent than a desire to benefit them. A survey of this sort, however, which fails

to take into account the progress we have made and the efforts we are currently making, is no good service toward our future. It omits, likewise—while stressing the need for research and training programs—to note the very ambitious programs already under way.

Whether these and other matters than those already cited are the results of inexcusable ignorance or mere bad judgment in presentation, we do not know. But we feel that a distinct disservice has been done us. If the report is a sample we want no "Planning Board" as proposed.

It is easier to defend against a direct attack by a sensation-seeking writer than to meet attack by inference. God preserve us from our well-intending friends!

ET TU, BRADY!

The diffusion of general health information in the columns of the daily papers, a practice of long standing and one in which many competent practitioners have engaged, seems to have its flaws.

Consider the following quotation from a recent column (Dr. Brady's) which is widely syndicated through the United States: "The more I read about psychosomatic medicine and the complaints or ailments known as 'neuroses' (this does not include mental disease or derangement of any kind) the more fervently I hope for the end of the whole childish business." The occasion is a denunciation of some 200 to 300 words which appears to be directed at the practitioners of psychiatry and of psychosomatic medicine.

Dr. Brady discusses the "phony diagnosis of 'neurasthenia.'" He is also unkind enough to give the obsolete alternative term of "nervous exhaustion" which today nobody believes fits the facts. He informs the public: "Within the past four or five years a whole new system of equivocation and obfuscation has come out of the war. The yakety-yakety-yak of this latest method of handling 'nervous' patients fills many magazines and books with what the exponents call psychosomatic medicine."

He quotes an unnamed professor of psychiatry as estimating that only about 1,000,000 persons of the 133,000,000 in the United States are "normal." That is a sweeping estimate and it is only fair to admit here that some of us can be careless with our figures and loose in our use of terms. The psychiatrist knows very well that "normal" used in this sense refers to the imaginary individual who has no single mental quirk, irrationality or symptom of disorder—however minor. One reserves this sort of talk, as a rule, for professional circles where it will be understood; or, if used in non-professional circles, the idea is usually carefully elaborated in the con-

text. To throw it before the general public as Dr. Brady does, without explaining what the psychiatrist means by it, is no service to health education. That, in days when psychiatry is making such strides toward general understanding, a medical man should go out of his way to scoff before laymen at scientific developments, is a somewhat surprising activity.

It is long since modern psychiatry, physiology, and psychosomatic medicine, all of which are related, have had to be defended from criticism of earnest investigators who were seeking to know the truth. It may be true that Dr. Brady feels bolder to write such taunts for a newspaper than he would, should he find himself addressing a gathering of physicians who were informed upon the subject in a place where his statements could be discussed in open forum.

When Dr. Brady uses words like "chicanery," "absurdity" and "quack" in discussing neurotic and psychosomatic conditions, his newspaper readers are in no position to judge of his competence in the matter. A newspaper doctor is simply applying these terms to people and to procedures which are already suspect by the generality.

It would be absurd to argue the reality of the neuroses with Dr. Brady. That is not the intent here. The intent is to point out that a public forum is not the place to ventilate medical prejudices. As the victims of those prejudices, we may think that we deserve better in the way of professional courtesy. We would not, for instance, ourselves embark on a crusade against writers of syndicated columns on medicine. Some of those writers, for instance, seem to know what they are talking about.

BOOK REVIEWS

The Thematic Apperception Test. By SILVAN S. TOMPKINS. 297 pages. Cloth. Grune and Stratton. New York. 1947. Price $5.00.

This book is a much-needed text of one of the more important projective techniques. There is need for a standardized method of analyzing and interpreting "Thematic" stories. Perhaps this book will provide such a system or lead to future development of a uniform procedure for all clinicians.

The method described by the author clearly depicts the usefulness of the thematic test in personality diagnosis, psychotherapy, play therapy and as supplementary interview material. Limitations, especially in the field of psychiatric disorders, are pointed out.

The first chapter contains an excellent compilation of historical and developmental data. The following four chapters deal with administration, scoring, interpretation and form analysis. The scoring system offered is rather elaborate; and in the words of the author, is, "time consuming microscopic analysis" of thematic stories. However, such a "microscopic analysis" yields a great volume of interpretative data and leads to greater accuracy of personality diagnosis.

The last five chapters are detailed discussions of personality analysis in: (1) the realm of social relationships; (2) work; (3) love; (4) family; and (5) the value of the thematic test in psychotherapy.

The book is well written and easy to follow. The author has included numerous typical responses to illustrate interpretative factors. This increases the usefulness of the work tremendously and provides for better understanding of individual interpretative points. As a whole, the book is excellent and is one which will be of value to both the student and the experienced clinician.

The Challenge of Marriage. By RUDOLF DREIKURS, M. D. 271 pages. Cloth. Duell, Sloan & Pearce, Inc. New York. 1946. Price $3.00.

Dr. Dreikurs has the so-called "background" to write this book. After his graduation in medicine from the University of Vienna, he turned his interest toward social psychiatry. He organized child guidance clinics and the first Mental Hygiene Committee in Austria. He was a close associate of Dr. Alfred Adler. After coming to the United States in 1937, he practised psychiatry. In 1942 he became professor of psychiatry at the Chicago Medical School. Through his close association with child guidance clinics, he learned to know more about the parents of problem children.

His book is properly named, for the ideas which he expresses are a challenge to all who have accepted marriage vows. He gives hundreds of ideas

for use by the lecturer or writer in social psychiatry. He deals with the psychological and social factors which are responsible for our present-day confusion in the problems of sex, love, and marriage.

Dr. Dreikurs does not define love too clearly but he is not to be condemned for this, since it cannot be done easily. "When we see two people living harmoniously together and showing nothing more than a feeling of devotion, responsibility and belongingness, we think of them not as lovers but as a 'couple.' We say that they are no longer in the romantic stage of their love, and maybe we feel just a trifle sorry for them . . . maybe romance is not what we think it is . . . no one can expect to be happily married to a Don Juan . . . romantic love serve mainly as stimulation to offset common sense and good judgment. This type of emotion seems to be chosen for the purpose of picturing promises which can never be fulfilled in real life. It is a daydream of a discouraged person, who does not believe in his own future happiness and seeks unrealistic pleasures to soften his despair."

Dr. Dreikurs agrees that there is a war going on between the sexes; that woman is no longer as dependent upon man as she once was and that any increase in marital discord coincides with change in the social relationship of the sexes. However, each person must develop his own pattern of life. The concept of sex and marital society begins at an early age when the little child believes that "the situation at home represents the whole world. And, therefore, the relationship between the parents appears as the only possible one between men and women. Thus the child constructs his conception of married life. Without realizing it, parents thus influence the child's attitude toward marriage . . . the child cannot understand the real meaning of words and ideas, (but) he can sense the significance of remarks. So children learn about the dangers of pregnancies, about the disgrace connected with sexual experiences. Much of what they hear about sex is linked with suffering, disgrace, disadvantage, or even disaster. Especially girls become aware early that the disadvantages and dangers affect women mainly. No wonder that women are more inclined than men to regard sexuality as brutal, inhuman and bestial . . . The language of love-making is defined by early sexual excitations molded by any new practice and experience. Our present behavior in love is trained and developed by all our previous experiences." Thus when we are in the process of choosing a mate, "we put into operation all that we have thought, expected and feared. The choice of a wrong partner can be regarded as the first step toward marital discord, or as the last step in a misguided approach toward the other sex. Many people make no step at all. To choose or not to choose—that is the question which plagues them eternally."

The discussion of living together is concerned with the individuals and with the techniques and methods they use in dealing with each other but techniques alone do not preserve marital happiness. It is the spirit that counts, the willingness to co-operate, the faith and confidence to generate an atmosphere of genuine kindness and tolerance. "The problems overtly blamed for the disruption of marital happiness provide only test situations through which erroneous attitudes can be brought to light."

Dr. Dreikurs advises that jealousy has no place in marital happiness. Possessors of this characteristic are difficult psychiatric problems. "They demonstrate with all their intellectual power the injustice and unfairness of their mates. They are seldom ready to be informed about themselves. They want a change in the behavior of the partner, not of themselves." The therapy of jealousy must be directed toward helping the person to understand himself, his conflicts, his outlook on life, his need for a sincere desire to be helped to correct faulty concepts and approaches.

To say that this review reports all the ideas contained in this book would be incorrect, but a review must end somewhere. In general, the book places the strongest emphasis upon the responsibility of each individual, through his personal attitudes, for the building of his own marital happiness.

Anatomy of the Central Nervous System. Its Development and Function. By STEPHEN WALTER RANSON, M. D., Ph. D., and revised by SAM LILLARD CLARK, M. D., Ph.D. 532 pages, including bibliography and index. Cloth. W. B. Saunders Company. Philadelphia. 1947. Price $6.50.

Sam Lillard Clark, M. D., Ph.D., has revised this eighth edition of a work which has been regarded as a standard text and has been widely used as such for more than a quarter of a century. New illustrations have been added.

There is considerable new textual matter and there is an important change in sequence of material to bring the collection of gross descriptive anatomy into a single section early in the text as an aid to the student. The chapters on clinical illustrations, and reflexes and reflex arcs have been redesigned with added material to emphasize, in the words of the reviser, "the significance of the nervous system to the interpretation of normal and abnormal physiology generally."

An important improvement is the clarification of definitions for "autonomic," "sympathetic" and related terms. If it helps to clear the exasperating confusion now experienced by medical writers, editors and dictionary makers through conflicting use of these terms, it will have been of signal service.

The Human Race. A Study in the Nature of Knowledge. By EMIL FROESCHELS. 197 pages with foreword and index. Cloth. Philosophical Library. New York. 1947. Price $3.00.

This is a brief but exceedingly scholarly presentation of the views of a distinguished medical man who for 15 years was a lecturer on "medicine and philosophy" in the Medical School of the University of Vienna. It appears to have been written from a profoundly religious backgound. The author holds that there are two varieties of knowledge, congenital and acquired, congenital knowledge including knowledge of the infinite and knowledge of God. Dr. Froeschels' concept of human psychology includes dynamic elements. He, however, substitutes the expressions "the non-expression-ripe" and the "expression-ripe" for the unconscious and the conscious of Freud. He observes: "Dogmatic psychoanalysis and its modifications . . . consider repression a psychic force that brings some psychic events into the 'unconscious' whence they may be hindered by the censor from rising into consciousness. I prefer to think of the censorship as a psychic force that hinders these events not from involuntary utterances but from becoming expression-ripe." There are striking and provocative passages in *The Human Race,* but so far as this reviewer is concerned, he is willing to leave it to the philosophers.

Psychotherapy in Child Guidance. By GORDON HAMILTON.. xxii and 340 pages. Columbia University Press. New York. 1947. Price $4.00.

A "bad child" is often one who is seriously disturbed and is in need of emotional guidance, according to Gordon Hamilton, professor of social work at the New York School of Social Work, Columbia University. Professor Hamilton argues in *Psychotherapy in Child Guidance* that a child who steals and fights and is disobedient and aggressive, actually may be emotionally sick.

While carrying special meaning for the professionally-trained psychiatric social worker and psychologist, Miss Hamilton's recent volume is a thorough study of the child guidance program of the Jewish Board of Guardians in New York, where—as it has already been established authoritatively—a long-sustained interest in combining social and psychological understanding in the study and treatment of children has reached its logical development. In *Psychotherapy in Child Guidance* Professor Hamilton expresses positive commitments in both the theory and the practice of child psychotherapy. The author, in this true scientific exploration, indicates that case work is an applied social science; and, to her, the social sciences have a fundamental link with dynamic psychiatry. This book formulates,

then, the very principles of psychotherapy, which work is to be carried on by a clinical team: case-worker, psychologist, and psychiatrist.

Professor Hamilton maintains the thesis that diagnostic evaluation is a combined responsibility, a continuous co-ordination of case worker and psychiatrist; and the rationale of her program rests on the premise that the social and emotional problems of children and parents are the legitimate concern of a psychiatrically-oriented social agency. And the author examines, too, the meaning of the term "psychotherapy." It is "not co-extensive with, nor should it be used as a synonym for, psychoanalysis," Miss Hamilton states. In holding that psychotherapy is any measure, physical or mental, which favorably influences the personality, Professor Hamilton realizes in her analysis that personality is not only a psychosomatic but also a psychosocial unit.

In *Psychotherapy in Child Guidance*, the field of parent-child relationships is certainly significant in terms of psychosocial interactions. The method the author uses in this study is descriptive rather than statistical. She draws voluminously from blocks of cases; and in such random sampling, over a period of approximately a dozen years, gains perspectives while clarifying trends. In handling the case histories, Professor Hamilton looks at the therapeutic process from two angles: namely, the clinical diagnostic, and the social and ego-patterns of functioning under age groupings. To the literature on psychotherapy with children, Miss Hamilton has contributed not only a philosophy but a set of objectives and methods. Social workers, teachers, clinical psychologists and others will find this book of value in the application of psychotherapy in child guidance.

Aftermath of Peace: Psychological Essays. By A. M. Meerloo, M. D. 218 pages. Cloth. International Universities Press. New York. 1946. Price $2.50.

Dr. A. M. Meerloo in his *Aftermath of Peace* argues that "psychology has to be, in the first place, descriptive and analytical," and, too it should attempt a study of man. In this little book the author deals with varied themes: treason and traitors, hatred, aspects of fear, problems of displaced people, atomic power, justice, psychological warfare. In none of these essays does he reveal a sufficiently lucid comprehension of the basic problems, though interspersed in these pages one finds revealing and interesting comments and viewpoints.

Perhaps it is too difficult in this chaotic postwar world—or it may yet be too early—to evaluate intelligently enough the psychological manifestations that people exhibit in the solution of their problems. Dr. Meerloo attempts "provisory" conclusions, based on his experiences of having spent more

than two years under German occupation, escaping in 1942, later to become director of the psychological department of the Netherlands Ministry of War in London.

Yet *Aftermath of Peace* is eloquent in places, and is even rather convincing as a document. The author obviously possesses an insight into the problems of his country, as well as of Europe; and his presentation of the material is both simple and graphic. But the volume does not deal with all significant facets and implications of the psychological incidentals of total war. To those concerned with, and eager to co-operate in, the shaping of the world-to-come, Dr. Meerloo's book offers sparse guidance for thinking.

Personal Adjustment. By KNIGHT DUNLAP. 446 pages. Cloth. McGraw-Hill. New York. 1947. Price $4.00.

Professor Dunlap's book appears to be written for lay consumption. It is, however, an excellent presentation of the concept of maladjustment and should be read by those interested in bettering their interpersonal and social relations. Understanding has been simplified by definition of all psychological and psychiatric terms which might confuse the layman. The book seems to be somewhat weighted on the sexual problems of adjustment; however, the discussions are of interest. Marital adjustment is discussed in detail with treatment of such topics as "Sex and Its Function in Human Life," "Marital Adjustment and Maladjustment," and "Choosing a Mate." Other chapters deal with the care and training of infants and children, foundations and applications of psychoanalysis and types of mental disorders.

The book is well written and should be of particular interest to those interested in the problem of human adjustment. Its biggest contribution will be to provide for the layman an understanding of the concepts of adjustment. It appears to be too elementary for the advanced student of behavior.

The Works of the Mind. R. B. Heywood, editor. 246 pages. Cloth. The University of Chicago Press. Chicago. 1947. Price $4.00.

This book consists of 12 essays by 12 scholars, administrators and artists, which were offered as a series of lectures at the University of Chicago in 1946. The general discussion is in reference to "the creative processes by which serious results may be achieved in the arts, in the conduct of educational and political enterprise, in the creative thought and scholarship."

Each particular area, i. e., art, sculpture, architecture, music, politics, legislation, administration, science, mathematics, history and philosophy, is discussed by an authority in the field, namely, Marc Chagall, Alfeo Faggi, Frank Lloyd Wright, Arnold Schoenberg, Heinrich Bruning, J. W.

Fulbright, Robert M. Hutchins, S. Chandrasekhar, John von Neumann, C. H. McIlwain and Mortimer J. Adler. The first chapter is a discussion of the concept of work by Yves R. Simon.

The purpose of the book is "to offer guidance and encouragement to the potential creator and to his audience, the general public." The authors have truly accomplished their purpose in a well-presented philosophical discussion of their topics. This book should prove of particular interest to those who are philosophically inclined and interested in the creative processes.

What You Can Do for High Blood Pressure. By PETER J. STEINCROHN, M. D. 191 pages. Cloth. Doubleday & Co., Inc. Garden City, N. Y. 1947. Price $2.50.

With this pocket-size book, Dr. Steincrohn is adding another volume to his series on medical subjects, particularly on those pertaining to the circulatory systems. These are designed to be helpful to the layman. His other books have been called, *You Don't Have to Exercise, Heart Disease Is Curable, Forget Your Age, What You Can Do for Angina Pectoris and Coronary Occlusion,* and *More Years for the Asking.*

Dr. Steincrohn warns that his present book describes no new discovery or secret but that it contains sound advice which will aid the pressure phobe to live a happier life. "One purpose of this book, then, is to break down preconceived and faulty notions which you may have about the immediate and far-off dangers which are inherent in the disease of which high blood pressure is a symptom." Too much emphasis has been placed upon this symptom, so that for many persons their chief concern is, "How high is my blood pressure?" "All right, if you won't tell me what it is, I know where I can find a doctor who will tell me. Why, the idea!"

Dr. Steincrohn describes the mechanical method of taking blood pressure and describes what hypertension means physiologically. He advises that a person with hypertension need not give up his way of living but that he must simply readjust his life by doing things in moderation. He states that one need not give up smoking tobacco or drinking liquor or stop eating what he needs. It is overindulgence which harms. In fact, Dr. Steincrohn recommends one ounce of alcohol twice or three times a day. Exercise, also, is needed but in moderation. In addition, "You are at the mercy of your own temperament. This is true when you are normal, and especially so when you suffer from high blood pressure. . . . Even-tempered persons usually are not candidates for hypertension. . . . Temper is a witch's brew." Hypertensives must learn "to live along at thirty miles an hour instead of the usual sixty."

Dr. Steincrohn advises that "The diagnosis of essential hypertension usually is a simple matter. However, when you consider all the pitfalls, you will be more patient with your doctor. . . . It is much better for you if your doctor considers well and long before giving you a decision."

Dr. Steincrohn's final chapter, "Faith, Hope—and the Will to Live," is well named, for it gives hope and understanding to the patient who has decided to accept fate too easily.

This book should be added to the doctor's "circulating library," located in the waiting room.

Psychiatric Interviews with Children. Helen Leland Witmer, Editor. Contributors: F. H. Allen, P. Blanchard, L. N. G. Dawes, H. S. Lippman, M. W. MacDonald, H. B. Moyle, B. Rank, and R. A. Young. vii and 443 pages. Cloth. The Commonwealth Fund. New York. 1946. Price $4.50.

Dr. Helen Leland Witmer has accomplished an admirable, psychological study in editing *Psychiatric Interviews with Children,* a volume which considers brilliantly the various ways in which psychiatrists in child guidance clinics utilize the therapist-patient relationship for therapeutic ends. Case records are introduced throughout the book; and we have sufficient evidence to commend the study for its stress on modern, dynamic psychiatric principles and methodology.

The contributors to the volume—all of whom are recognized authorities in psychiatry—define child guidance as a new form of social service in which psychiatrists and psychiatric social workers co-operate in helping parents and children resolve the difficulties they encounter in living together. The editor points out succinctly that present child guidance practice is not based on a single, well-integrated body of theory, and that some of its divergencies reflect only partly articulated differences in basic assumptions about human conduct.

The examples of child guidance psychiatry are necessarily limited to interviews with children; other aspects of a psychiatrist's work in a clinic, and other means by which he may make himself useful to children and their parents are omitted. This most technical side of psychiatric work includes guidance setting and procedures, and the interviews with children are supplemented by notations about the social work with parents. The following factors are considered rather thoroughly throughout *Psychiatric Interviews with Children*: diagnostic categories; the concept of "neurosis"; differential diagnosis; the diagnostic process; therapeutic relationships; the dynamics of therapy; treatment methods.

The 10 case records selected for analysis in the book certainly are representative of the principles by which recognized therapists have effectively dealt with difficulties that are typically present in child guidance work. This study reveals strikingly, too, the essential unity of the therapeutic processes used by psychiatrists in different clinics, despite the fact that the methods of various schools of psychiatry themselves differ. Perhaps this volume is not the final word on the problem of psychiatry and its relationship to children, but it is one of the most penetrating analyses that have come to the attention of this reviewer. *Psychiatric Interviews with Children* should be of practical value not only to psychiatrists who deal with children in particular, but to social case workers, psychotherapists and pediatricians. Clinical psychologists will also derive from this book a better understanding of child guidance methods.

The Years After Fifty. By WINGATE M. JOHNSON, M. D. 146 pages. Cloth. Whittlesey House. New York. 1947. Price $2.00.

Dr. Johnson's book is one of the volumes included in the *Whittlesey House Health Series,* edited by Dr. Fishbein. It is not a large book but it is full of sound advice which can help those who have passed the half-century mark, to live more calmly, happily, fruitfully and philosophically during the rest of their lives. It is written by a "family" doctor who is chief of the private diagnostic clinic, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C.

Dr. Johnson advises that as we reach the age of 50 we should take an honest inventory of our physical and mental being, that we should clearly understand the common bugaboos that mature people fear, such as high blood pressure, heart disease, cancer, loss of sexual vigor, mental deterioration, economic insecurity and dying. He also write about dietary fads and fancies, respiratory illnesses, rheumatism, arthritis, vitamins, internal glandular secretions, and disorders of the digestive system. He discusses all of these subjects in clear and simple language and in such a manner that the lay person will not become alarmed at the changes which occur at that age. Dr. Johnson is not an "alarmist."

He states: "Some wit has described the three ages of man as (1) when he boasts of the pretty girl he dated last night, (2) when he tells everyone of the good dinner he had the night before and (3) when he is proud of the good bowel movement he had this morning." How true this characteristic is in the aging person. One only need listen to the radio to estimate how important this stage of bowel interest really is. Dr. Johnson recommends less use of catharties, more relaxation and less worry if the evacuations fail to occur on eastern standard time.

He states that, "The man who possesses a well-integrated personality, who takes life philosophically, and who has a wide range of interests, is likely to keep his mental faculties to a far greater degree than is the one who is not so well adjusted." The man over 50 must learn to accept exercise and recreation in moderation.

Dr. Johnson preaches that every person should prepare for old age; that this preparation should begin in young adulthood; that "When one's mind becomes so fossilized that it refuses hospitality to new ideas, he is already old, no matter what his birth certificate says. As long as one retains a keen interest in what is going on around him, is in touch with progress in his business or profession, and has one or more thoroughbred hobbies to ride, he is still young no matter how white his hair."

Youth After Conflict. By GOODWIN WATSON. 300 pages. Cloth. Association Press. New York. 1947. Price $4.00.

Goodwin Watson discusses the general social changes following war and their effect on the youth of the world. His discussions extend through three wars, i. e., The Civil War, World War I, and World War II. Chapter I is an excellent review of the post-Civil War period. He concludes that, "Youth had not at that time emerged as a group to be given separate consideration—youth were people." A second conclusion is that youth was greatly in demand, with many vocational opportunities available, in contrast with the insecurity of the youth of today. The post-war period of the 1860's and 1870's shows expansion of educational facilities and opportunities.

After World War I, youth emerged as a special group with specific problems. New fashions were followed by the woman, and women's smoking became more prevalent. In general, women were demanding greater recognition and quality with men. Educational expansion was rapid; religious trends were moving away from the orthodox position; greater personal independence was sought, but no youth organizations were set up.

The after-effects of war are discussed in detail and the concept of "modernism" is reviewed. Finally, the world of the 1950's is forecast—based on the observations and studies of the trends of the past. Forecasts are given for such topics as research, technology, economics, education, health, politics, family and sex relations, the arts, spiritual values, etc. The last chapter deals with "The New Post-War Youth," discussing their new epoch, their health, their schooling, their work, their sex attitudes, etc.

Watson has done an excellent piece of work in analyzing American youth and forecasting its future. This is a book well worth reading, especially by those who are concerned about America of the next decade.

Let's Talk About Your Baby. By H. KENT TENNEY. xi and 115 pages. Cloth. The University of Minnesota Press. Minneapolis. 1947. Price $1.50.

In a whimsical, intelligent, smooth book entitled *Let's Talk About Your Baby,* Dr. H. Kent Tenney maintains the thesis that the care of a baby can be made simply a slavish adherence to a routine, whereas it really should be a constant source of enjoyment. However, the author certainly has the faculty of adding the "light touch" to a serious treatise on what is obviously an important subject. At the same time he advances excellent advice throughout its pages.

Dr. C. Anderson Aldrich, director of the Rochester Child Health Project in Minnesota, says the following about this little book: "There can be no doubt that it is preferable to create an attitude of calm, happy acceptance in a mother rather than one of earnest compulsion toward her baby if we expect to have well-adjusted children. . . ." Truly, this book by Dr. Tenney (who is associate professor of pediatrics in the University of Wisconsin Medical School) is different from most books on babies: It possesses facile readability; it is clever and interesting, with sufficient graphic illustrations; it has a common-sense approach; it is packed with practical information—and it is wholesomely free from mere dogmatism. More, it is an unprejudiced book on babies, factual, clear, authoritative, fundamental, imparting to young mothers especially sound medical advice so clearly and so humanely that they cannot fail to be reassured in their marvelous task of child-rearing.

The Needle's Eye. By TIMOTHY PEMBER. 341 pages. Cloth. Reynal and Hitchcock. New York. 1947. Price $3.00.

This novel is a love story, a study of the growth of character in a group of people living in England in the middle 1930's, and the story of their reaction to the social problems of the times. It is the tale of a young man living with his grandparents in a small English village. He is unacquainted with life outside an English public school; and, when he becomes friendly with an active radical Socialist and his daughter, he is confused by the great disparity between their ideas and the conservative ones of the schools and of his grandfather. After a feeble attempt to study the profession his grandfather has picked out for him, he takes a laboring job and casts his lot with the Socialists.

Characterizations of the principals of the story are thorough and realistic; and the author shows insight and understanding of the personalities of the less sympathetic characters as well as of the hero and heroine.

The Doctor's Job. By CARL BINGER, M. D. 235 pages. Cloth. W. W. Norton & Co., Inc. New York. 1945. Price $3.00.

For this book, Dr. Binger, who is now on the faculty of the Cornell Medical College, received the Norton Medical Award—offered to encourage the writing of books on medicine and the medical profession for the layman. It was written because Dr. Binger felt that he wished to explain to the general public the problems of the doctor and dispel antagonism toward the doctor caused by failure of the layman to understand the medical specialties and the goals which the medical profession is trying to reach.

Dr. Binger starts out to show how knowledge in medicine has so expanded that specialization in medicine has become necessary; that the family doctor of years gone by could not possibly cover all of the angles of medicine today. He stresses the importance of a sincere patient-doctor relationship. In plain talk, he explains to the layman the meaning and objectives of psychoanalysis and of psychiatry. He defends these specialties in a manner to create sympathy and understanding about the treatment of neurotic problems. He attempts to give the public a sensible understanding of the causes and treatment of stomach ulcer, of allergy, asthma and tuberculosis and of high blood pressure. He describes the methods of control of disease, the need for further attention to stimulate the mental health of those suffering from chronic disease and the advances which have been accomplished in the treatment and prevention of disease. Dr. Binger describes the types of "socialized" medicine now in use and cites their advantages and disadvantages. Finally he compares the physician of the past with the physician of today.

Dr. Binger has written in a scholarly fashion. His book can be safely recommended to the layman; and the physician who reads it will have information which he can pass on to his patient.

Hypnotism Comes of Age. Its Progress from Mesmer to Psychoanalysis. By BERNARD WOLFE and RAYMOND ROSENTHAL. 272 pages with bibliography and index. Cloth. The Bobbs-Merrill Company. Indianapolis. New York. 1948. Price $3.00.

This is a non-technical review of the history of hypnotism and its current therapeutic uses. It is written for laymen by an experienced writer on scientific subjects and a man who saw much use of hypnotism in the treatment of war neuroses. The style is simple and the descriptions clear. This book should be of particular use to the therapist or social worker who wishes to explain hypnotic procedures to friends or relatives of prospective hypnotic patients.

Take This Woman. By LINDSAY HAYES. 308 pages. Cloth. The Macmillan Company. New York. 1947. Price $3.00.

This is a novel of the marriage of neurotics. Trump was rigid, self-centered, mother-dominated. He had not been cured of being a college boy. Lisa's father meant too much in her life. She had had an unhappy childhood, a pre-marital love affair and had failed at college.

With this background and the help of Trump's and Lisa's two little children, the author takes the couple through a *psychiatrically-advised* separation, escorts Lisa to a mental hospital, Trump to a psychoanalyst, and contrives a happy ending.

The book is well written and the characters well drawn. It is filled with true-to-life incidents; but one is privileged to doubt whether there ever was a psychoanalysis like Trump's or whether any such tangled problem ever was solved so quickly, simply and satisfactorily.

How to Keep Happily Married. By JOSEPH L. FOX. 213 pages. Cloth. Dorrance & Co. Philadelphia. 1947. Price $2.50.

This book is not written by a doctor or by a psychologist but by a practising attorney in the field of domestic relations and divorce. In his preface the author states: "The need for a treatise setting forth in clear and concise language, rules of conduct and behavior, to assist young couples about to enter into matrimony and those already married, in preserving the institution of marriage, as a vital, necessary, and component part of our civilization, impelled me to write this book." He advises that "One out of every three marriages ends in divorce; that the reduction in the number of divorces does not lie in more stringent divorce law . . . but . . . in teaching the youth contemplating marriage and others also entering the matrimonial state, things they should know about marriage, which by reason of ignorance and taboos and religious interpretations have not been made available for general knowledge."

After describing the ancient customs of marriage and the significance of the wedding veil, the wedding ring, etc., Fox describes in medical terms the anatomy and physiology of the sexual organs, and he really does a very good job. He emphasizes that the experiences during the first night of marriage often leave the bride with "a lasting impression of disillusionment, a breaking of the spell of romance, turning love to dislike and even hatred. . . . physical loving is not instinctive amongst humans; it has to be cultivated and can be learned only by experience, observation and study." The author describes in detail the several parts of the love drama

ending in sexual satisfaction. He is not averse to discussing frankly birth control, sex rhythm, sexual maladjustments and the need for "planned" families.

The remaining larger part of the book deals with simple yet sound advice so often useful to those desiring continued marital happiness. The following are representative quotations:

"Marriage, with an ensuing sanctified comradeship, made permanent by love and mutual respect, constitutes true happiness."

"Too often, after marriage, there is a tendency on the part of the man and woman to take each other for granted; close proximity and possessory instincts augment this tendency."

"A wife should retain her innate modesty; the daily acts of hygiene, immodest undressing, the performance of her toilet and careless exposure and abandonment of essential principles of modesty, have a tendency to lessen the effect of her feminine claim upon her husband."

"Woman, having the need for expressions of tenderness, should be careful to avoid acts that are motivated by selfishness; the devotion of a husband toward his wife does not give her special privileges; the relationship of marriage should in all respects be mutually reciprocal."

"Concessions made in the spirit of love, engender equal concessions from the person beloved; concession and compromise rendered in this spirit act as a buffer or shock absorber and constitute a protective piece of apparatus that saves the entire structure of marriage."

"Never let a day pass without mending a quarrel; never meet without a loving welcome; do not repress, but instead, confess a fault and ask forgiveness for it; let the happy days of the marriage have a tender spot in memory's recollection of love."

"With love gone or grown cold, inharmonies are stressed and antagonisms are rendered more bitter by mutual recriminations and retaliatory taunts hurled by one at the other."

"While it is difficult for a woman to forgive her husband's extra-marital proclivities, yet, if she loves him, she will forgive him and strive with might and main to care for and rectify whatever there is of fault in her husband or herself that lures him off the reservation."

"We must here point out that prior to World War I, premarital sex experience on the part of a girl was deemed shameful. As a result, the vast preponderance of girls, it is safe to say about ninety percent of the girls, were virgins when married. Such statistics as are available, reveal that by 1932 the rate of girls marrying having premarital experience had risen to

about fifty percent. Immediately before World War II, the rate of percentages of virginal girls marrying had decreased to thirty-five percent, so that at least sixty-five percent had premarital sexual experience. A survey establishes the equally astounding fact that since World War I straight through to the conclusion of World War II, at least one-quarter of the married women had committed adultery during some period of their marriage."

This book contains not only this type of sound marital philosophy and information but has a good list of reading references and a good index. It is especially recommended for the layman, married or "hoping."

Our Children Are Cheated: The Crisis in American Education. By BENJAMIN FINE, Ph.D. xi and 244 pages. Cloth. Henry Holt & Co. New York. 1947. Price $3.00.

In *Our Children Are Cheated* by Benjamin Fine, we have a little volume of constructive suggestions, penetrating observations, and deep-rooted love of the teaching profession. Dr. Fine, the education editor of *The New York Times*, is an able reporter and keen analyst of trends in education throughout the United States. This book is an expansion of the material that appeared in the *Times* on conditions in the educational field which Dr. Fine experienced in his swing around the country in 1947.

The thesis of this book is basically understandable: It is that the public schools are a vital part of our democracy, and therefore should be maintained at a high level of operation. The author sees the problem of education in terms not only of the teachers themselves, their qualifications, their inadequate pay in many sections of America; but also in terms of school buildings in disrepair, inadequacies of curricula, the plight of the colleges, the effect of the recent war. To be sure, he concerns himself with the primary and essential needs of education for the future.

Dr. Fine argues that it is "only through an educated, intelligent electorate [that] we can maintain a democratic system." He believes deeply, earnestly, in our free public school system. In his survey, the author talked to hundreds of educators, teachers, board of education members, civic leaders, parents, laymen—in the hope of making them see his viewpoint, too, while he learned from them, as impartially and as accurately as possible, about our American public school system. In *Our Children Are Cheated* we learn, in turn, that many of our school systems have broken down; education faces a serious crisis; hundreds of communities lack adequate teachers; teacher morale is low.

In fine, our children *are* being cheated in their education; and Dr. Fine recommends a good part of the solution. He tells his story in a constructive spirit. He maintains that our democracy is at stake: Good schools are necessary if we want our democratic way of life to flourish. The author states his case with conviction, erudition and fairness; and enumerates the following among his more important recommendations: higher certification standards for teachers, increased salaries for teachers, higher caliber teachers, increased state supervision and aid, equality of educational opportunity for all children, improvement of curricula, and better health programs.

People in Quandaries: The Semantics of Personal Adjustment. By WENDELL JOHNSON. xiv and 532 pages. Cloth. Harper & Brothers. New York. 1946. $3.00.

Many of the maladjustments of modern life spring from man's failure to understand and use words and other symbols to advantage. Dr. Wendell Johnson, who is professor in the departments of speech, psychology, and child welfare of the University of Iowa, writes with great fluidity and in a captivating style on just this theme in his brillant *People in Quandaries*. The problems with which the author deals are the ones that plague all of us as we try to get along with ourselves and with each other—in a world that grows more complex constantly.

Dr. Johnson writes of the problems—in semantics, in psychology, in logic, in thought—of our homes and communities, our industries and schools, our nation and our world. He speaks of scientific living, the language of maladjustment, the process of abstracting, research in language behavior, and related subjects. In other words, the author examines the relation of language to other aspects of human behavior. The result is a stimulating and unusually practical book.

The author shows how the scientific method, including the scientist's efficient way of using language, can be applied to help us deal effectively with our personal and social problems in life situations generally. Dr. Johnson upbraids us for having developed a strong inclination to take for granted whatever is familiar or customary. Our notions of what is "normal," he points out, are therefore determined largely by the behavior, beliefs, attitudes, and social conditions which man comes to accept as "right" or "natural."

The thesis of *People in Quandaries* is that "general semantics can be put to use in many ways by doctors, lawyers, teachers and students, editors and writers, etc., through the long catalogue of human occupations." Dr.

Johnson accordingly addresses himself to a varied reading public—to all, in fact, who are sensitive to opportunities for personal growth and the enrichment of our general culture. This book is not only sound and practical, but also interesting and readable. The "world of words" is made exhilarating and fresh through the pen of this author; and Dr. Johnson's suggested exercises in semantics that conclude *People in Quandaries* are certainly noteworthy.

Del Palma. By PAMELA KELLINO. 254 pages. Cloth. E. P. Dutton & Co., Inc. New York. 1948. Price $2.75.

No reader will have a neutral reaction toward this book. It is either very bad or very good. The reaction is necessarily personal; and the reviewer's reaction is that it is very good. It is the story of the "possession" of a living woman by a dead one. It has been done before; Poe did it in *Ligeia;* the reviewer will invite the ire of the literary critics by the assertion that he prefers Miss Kellino's version; it is psychologically more credible. Miss Kellino is the wife of James Mason, the English actôr, who drew an astonishingly effective illustration for the dust jacket.

I Am the Cat. By ROSEMARY KUTAK. 249 pages. Cloth. Farrar, Straus and Company. New York. 1948. Price $2.50.

I Am the Cat is a psychological mystery story with an unusual angle; that is, the author indicates that it is based on the theories expounded in *The Unknown Murderer* by Theodor Reik. The reviewer feels that anyone well acquainted with Reik will solve the mystery at least as readily as the psychiatrist-detective. But, for all that, it is fine, light reading for anyone with a psychological background.

A Street Car Named Desire. By TENNESSEE WILLIAMS. 171 pages. Paper boards. New Directions. New York. 1947. Price $2.75.

This is the well-known play which has had such success on Broadway. It is the somewhat sordid tragedy of a woman who fell in love with a homosexual and took refuge in promiscuity and alcohol. The supporting characters are as unpleasant a set as this reviewer has any desire to meet—neurotics, psychopaths and the plain, unfeeling, selfish. The character drawing is exceptionally good and this book is worth the attention of all who take an interest in psychopathology.

Great Mischief. By JOSEPHINE PINCKNEY. 247 pages. Cloth. The Viking Press. New York. 1948. Price $2.75.

Precisely what the "great mischief" of this highly entertaining novel is about is a matter not entirely clear to the present reviewer—or apparently to numerous other reviewers of this exceedingly popular book. Take one nineteenth century apothecary, add one young and beautiful blue-eyed witch, shake well, and administer *cum grano salis* as indicated. Whether Miss Pinckney's fantasy is an excursion into demonology or into schizophrenia probably doesn't matter.

The Indifferent Blade. By LILIAN VAN NESS. 303 pages. Cloth. Doubleday and Company, Inc. Garden City, N. Y. 1947. Price $2.75.

Connoisseurs of "the pale cast of thought," this is your novel! Its characters do not "do something." Instead, things happen to them, and they brood about them. The brooding fills pages, but results in no progress, whatever progress is, and wherever it is. According to the blurb sheet, ". . . the author has imparted to the story that feeling of inevitability which is the essence of true tragedy." In this case, "essence" is a polite word. Perhaps the book is so well and smoothly written that nothing quite seems to come off with satisfactory impact. People die of abortion, go "insane," and shoot the wrong other people, all in a most reasonable and decorous fashion. In the end, the Oedipal and pre-Oedipal guilt is washed away by having the principal character saunter off to join the Canadian army. His career in the said army is left, mercifully, to the imagination. However, considering his past, it may be well that the Allies have papers to prove that they won the war; this fellow seems the sort to have cluttered up any war effort.

In Henry's Backyard. The Races of Mankind. By RUTH BENEDICT and GENE WELTFISH. 50 pages. Illustrations. Paper boards. Henry Schuman. New York. 1948. Price $2.00.

This is one of the most trenchant, and at the same time one of the most amusing, pleas for more tolerance among the races and religions of man which this reviewer has seen.

It is principally a picture book based on the cartoon movie, *Brotherhood of Man,* and the accompanying brief text was adapted by two distinguished anthropologists from the Public Affairs Committee pamphlet, *Races of Mankind.*

The initiative for the movie, and hence for the book, comes from the United Automobile Workers-CIO of all people—the reviewer having in mind that Detroit has been a hotbed of racial animosity.

This book is suitable for children as well as for adults. As an instrument toward the production of greater tolerance, it should be just what the UAW hoped their movie would be—"a contribution to the American people."

This Man and This Woman. By FREDERICK W. BRINK. 79 pages. Paper boards. Association Press. New York. 1948. Price $1.50.

The author of this small book is a Presbyterian minister. He has written a thoroughly enlightened little volume of advice for persons contemplating marriage.

His observations are sound in general although some of the language seems quaint to those used to psychiatric frankness. For the very reason of this ministerial restraint, the book may be more valuable to persons with extremely religious backgrounds than the conventional psychiatric advice. It is by no means exhaustive but it does cover the principal problems adequately, including that of mixed marriages—meaning marriages of persons of different religious faiths. Treatment of this particular topic seems eminently fair, and references for further reading are included in the book's small bibliography.

The reviewer thinks this book is an excellent one to recommend to any person with a conventional religious background who would not readily accept psychiatric advice. The clergy should make good use of it.

CONTRIBUTORS TO THIS ISSUE

SENTA JONAS RYPINS. Mrs. Rypins, born in New York City, was graduated from Barnard College in 1915. In 1919 she was married to Dr. Harold Rypins who was later secretary of the New York State Board of Medical Examiners. Mrs. Rypins has made numerous translations of medical articles and books, including *Genetics and Schizophrenia* for Dr. Franz Kallmann. She was co-author, with Oskar Seidlin, of a children's book, *Green Wagons.* From 1922 to 1946 she worked on a project of the New York State Department of Mental Hygiene in connection with its history of 20 state hospitals.

Mrs. Rypins, who suffered a hearing loss in childhood, has always been interested in social service for the hard of hearing and is at present with the New York League for the Hard of Hearing.

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DAVID J. FLICKER, M. D. Dr. Flicker, born in Newark, N. J., in 1910, is a graduate in medicine of the University of Louisville in 1933. He did postgraduate work at the New York Post-Graduate Hospital and the New York State Psychiatric Institute. He is assistant attending neurologist and psychiatrist at the New York Post-Graduate Hospital, is chief of clinic and attending neuropsychiatrist at the New York Post-Graduate Dispensary and is attending neuropsychiatrist at St. Mary's Hospital, Passaic, N. J., and the Passaic General Hospital. He is a diplomate of the American Board of Psychiatry and Neurology.

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IDA BRAIMAN, M. S. Ida Braiman, a native of Brooklyn, entered social work as an apprentice social worker at Brooklyn State Hospital five years ago. She received her degree of master of science in social work from the New York School of Social Work in 1945. She resigned from state service in December 1947, after her marriage, and is now living in New Jersey.

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PATRICIA FARRELL, M. S. Miss Farrell is senior social worker in the social service department at Brooklyn State Hospital. She became an apprentice there about five years ago and received her master of science degree in social work from the New York School of Social Work of Columbia University in 1945. During the war she was medical field agent in the selective service system.

EUGENE DAVIDOFF, M. D. Dr. Davidoff, born in New York City in 1901, was graduated from the University of Iowa College of Medicine in 1927. After a general internship he entered the New York State hospital service at Manhattan State Hospital in 1930. He was appointed senior clinical psychiatrist at Syracuse Psychopathic Hospital in 1936 where he was in charge of research and of the mental hygiene clinic. He was also assistant professor of psychiatry at Syracuse University. He later served as clinical director at Willard State Hospital and as assistant director at Craig Colony. He served in the army from 1943 to 1946, leaving with the rank of lieutenant colonel. He is now assistant chief of the neuropsychiatric section of the New York Branch of the Veterans' Administration.

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MABEL DAVIS. Miss Davis is chief occupational therapist at the Veterans Administration Hospital, North Little Rock, Ark. A graduate of the Philadelphia School of Occupational Therapy in 1932, she later served at the New York State Psychiatric Institute, Rockland State Hospital and Craig Colony where she was chief occupational therapist and reorganized the occupational therapy department. From 1943 to 1945 she was head occupational therapist of the army's Hammond General Hospital at Modesto, Calif., where she was cited by General Sommerville for setting up occupational therapy training systems to be used "as a model to be followed by all hospitals in that command."

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CLAUDE F. HUBLEY. Mr. Hubley is bandmaster at Marcy State Hospital, Marcy, N. Y. He has been a professional musician for 30 years. During the first World War, he was an instrumental instructor in the United States Army; he later played with the Cincinnati Symphony Orchestra and with Sousa's Band. He plays the French horn. Since 1928, and before going to Marcy, he was a member of numerous orchestras, bands and other musical organizations in central New York.

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EDMUND BERGLER, M. D. Dr. Bergler is a psychoanalyst who has been in private practice in Vienna and New York since 1927. He was formerly assistant director of the Vienna Psychoanalytic Clinic and has been a lecturer at the New York Psychoanalytic Institute. He is the author of a large number of books and scientific articles.

NOLAN D. C. LEWIS, M. D. Dr. Lewis has been director of the New York State Psychiatric Institute since 1936. Born in 1889, he received his medical degree from the University of Maryland and later studied at Johns Hopkins and the University of Vienna. After a number of years as a pathologist, he became director of clinical psychiatry at St. Elizabeths Hospital in Washington. He was engaged principally in teaching activities when he was appointed director of the New York State Psychiatric Institute. At present, besides heading the institute, he is professor of psychiatry at the College of Physicians and Surgeons of Columbia University. He is the author of numerous scientific books and articles. He recently succeeded the late Smith Ely Jelliffe, M. D., as editor of *The Journal of Nervous and Mental Disease* and of *The Psychoanalytic Review.*

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JOHN A. BIANCHI, M. D. Born in Brooklyn in 1902, John A. Bianchi was graduated from St. John's College in Brooklyn. He received his degree of doctor of medicine and surgery from the Royal University of Naples, Italy, in 1928. After two years of a general internship, he joined the staff of Brooklyn State Hospital in 1930. He is now a supervising psychiatrist and acting assistant director in charge of shock therapy.

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CARMELO J. CHIARELLO, M. D. Dr. Chiarello is a graduate of the Long Island College of Medicine in 1933. After internship at St. Peter's Hospital, Brooklyn, and a residency in pediatrics at the New York Foundling Hospital, he joined the New York State hospital system in 1935 and has remained with the state hospitals until the present time. Previous publications by Dr. Chiarello have appeared in THE PSYCHIATRIC QUARTERLY and *The Journal of Nervous and Mental Disease.*

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JOSEPH R. GRASSI. Mr. Grassi, widely known as a clinical psychologist and writer on subjects relating to clinical psychology, was co-developer of the Graphic Rorschach method referred to in his article in this issue of THE PSYCHIATRIC QUARTERLY SUPPLEMENT. A graduate of Hobart College in 1938, Mr. Grassi received his master of arts degree from the University of Rochester in 1939. Following service at Gowanda State Homeopathic Hospital and at Fairfield State Hospital, Newtown, Conn., he served in the United States Army from 1942 to 1946, leaving with the rank of captain. Recently he was director of the psychological laboratories at Fairfield State Hospital. At present he is assistant professor and chief psychologist at Graylyn Hospital, Bowman Gray School of Medicine, Winston-Salem, N. C.

ED R. CLARDY, M. D. Dr. Clardy was graduated from the University of Tennessee, College of Medicine, in 1929. He interned at St. Vincent's Hospital, Jacksonville, Fla., 1930, served in the psychiatric clinics of the University of Tennessee in 1932 and became instructor of neurology and psychiatry at the University of Tennessee, 1933. During the past 10 years, he has been physician in charge of Rockland State Hospital Children's Group as well as child guidance physician for the Rockland State Hospital district.

He has published a number of papers on child psychiatry. Two recent publications were: Schizophrenic-like reactions in children, in THE PSYCHIATRIC QUARTERLY, 15, 1, January 1941; and Schizophrenic-like reactions in children (second series) in THE PSYCHIATRIC QUARTERLY, 19, 4, October 1945.

LEO P. O'DONNELL, M. D.

Leo P. O'Donnell, new director of Newark State School, was born in Anderson, S. C., where he attended grammar and high school. He entered the United States Army in World War I. Upon returning, he took his premedical work at Clemson College, Clemson, S. C., and then entered the Medical College of the State of South Carolina from which he was graduated in 1925 with the degree of doctor of medicine.

Dr. O'Donnell was in private practice for a short time in South Carolina, and then entered the New York State service, Department of Mental Hygiene, on April 1, 1926, at St. Lawrence State Hospital, where he advanced to senior assistant physician. In February 1932, he was transferred to Rockland State Hospital where he was promoted to director of clinical psychiatry in November 1934. He held this position until February 15, 1938, at which time he transferred to Pilgrim State Hospital as first assistant physician.

He was called to active duty in World War II on May 2, 1941. He served as psychiatrist at Fort Jay, N. Y., as chief of the neuropsychiatric section of the 210th General Hospital and 368th Station Hospital in the Canal Zone, and returned to the States where he served as assistant chief of the neuropsychiatric service and assistant executive officer of Mason General Hospital until October 1945, at which time he was on terminal leave. He received the Army Commendation Ribbon. After his release from the service, Dr. O'Donnell returned to Pilgrim State Hospital, as associate director and continued there until May 1, 1947 when he was appointed director at Newark State School.

Dr. O'Donnell is a diplomate in psychiatry of the American Board of Psychiatry and Neurology, a fellow of the American Medical Association, a fellow of the American Psychiatric Association and a member of the American Psychopathological Association, as well as a member of the Wayne County and New York State Medical Society. Dr. O'Donnell was married to Miss G. Marian Potter of St. Regis Falls, N. Y., on July 18, 1927. They have a daughter, Mary Patricia, who is now 19.

LEO P. O'DONNELL, M. D.

NEWS AND COMMENT

HENRY M. CHANDLER, M. D., DIES AT 68

Henry M. Chandler, M. D., associate director of Rockland State Hospital, Orangeburg, N. Y., died on October 19, 1947, in New York City following an operation at St. Luke's Hospital. He had been ill for more than a year. He had been in New York State hospital service since 1924.

Born in New Jersey in 1879, Henry M. Chandler was the son of Dr. William Jessup Chandler, a widely-known surgeon. A graduate of Princeton, Dr. Chandler received his medical degree from Albany Medical College in 1903. After general internship and some years of general practice, he joined the staff of the New Jersey State Village for Epileptics in 1913, where he served as senior assistant physician.

In 1917, Dr. Chandler joined the New York State hospital system at Manhattan State Hospital. From 1918 to 1924, he served in Indiana and Connecticut state hospitals and as director of a private institution in Connecticut. He rejoined the New York State system in 1924 as senior assistant physician at Utica State Hospital, later serving at Kings Park. He became first assistant physician at Rockland in 1930 and associate director in 1945. Dr. Chandler was a fellow of the American Psychiatric Association and a member of various other professional groups. He was a diplomate of the American Board of Psychiatry and Neurology.

Dr. Chandler leaves his wife, Dr. Jennie S. Chandler, who is a supervising psychiatrist at Rockland State Hospital, a son, Henry M. Chandler, Jr., who is assistant professor of electrical engineering at Princeton, and a daughter, Mrs. Stephen N. Dilworth of Tenafly, N. J.

VETERANS ADMINISTRATION OPENINGS

The Boston office of the Veterans Administration has requested this journal to note the availability, as of July 1, 1948, of several openings for residency training in neuropsychiatry. The training period is from one to three years, and the appointments are in Massachusetts and Vermont.

MARCY "MIRROR" IS A YEAR OLD

The *Marcy Mirror,* mimeographed publication for employees and patients of Marcy State Hospital, Marcy, N. Y., observes its first anniversary with the issue of March 1948. The *Mirror* is edited and published by the members of the educational program English class at the hospital. It includes contributions from patients, employees and members of the medical staff.

EDWARD THOMAS DEVINE, Ph.D., IS DEAD AT 80

Dr. Edward Thomas Devine, former head of the Charity Organization Society of New York, died in Oak Park, Ill., on February 27, 1948, at the age of 80. Widely known as an author and lecturer, Dr. Devine had held the position of professor of social economy at Columbia University and had been professor of social economy and dean of the graduate school at American University, Washington, D. C. He was the author of a number of books on social and philanthropic problems.

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RESIDENCIES AT KINGS COUNTY HOSPITAL

Sam Parker, M. D., director of psychiatry of the psychiatric division of Kings County Hospital, Brooklyn, has announced that the hospital has been approved for residency training and has a number of residencies available for appointment. Kings County Hospital is affiliated with the Long Island College of Medicine; and opportunities for degrees in graduate work are available for residents. The New York City Department of Hospitals has a standard resident's salary of $1,560 plus maintenance.

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PSYCHOSOMATIC ANNUAL MEETING

The American Society for Research in Psychosomatic Problems is conducting its annual meeting May 1 and 2, 1948 at Chalfonte-Haddon Hall, Atlantic City. General sessions are scheduled for Saturday, May 1, with the business meeting for members only, and a further general session on Sunday morning.

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MENTAL HEALTH COUNCIL TO MEET

The National Advisory Mental Health Council has announced its next meeting for May 14 and 15, 1948 in Washington, D. C. The members of the council are: Dr. Edward A. Strecker, Dr. William C. Menninger, Dr. John Romano, Dr. David M. Levy, Dr. Alan Gregg and Dr. Karl M. Bowman. Oscar R. Ewing, federal security administrator, announces the purpose of the conference is to obtain recommendations for feasible national mental health goals for the next 10 years.

FIRST PSYCHIATRIC AIDE AWARD ANNOUNCED

Walter Starnes, psychiatric aide at the Winter Veterans Administration Hospital of Topeka, Kansas, has received the first National Mental Health Foundation Psychiatric Aide of the Year Award, a sum of $500 with a citation. Among the five candidates who received honorable mention with $50 awards was Roy Kimberling of Middletown State Homeopathic Hospital, Middletown, N. Y.

SCHIZOPHRENIA IS CONFERENCE SUBJECT

The New York State Department of Mental Hygiene has announced that the spring interhospital conference subjects will be devoted to schizophrenia. The downstate conference will be held at the New York State Psychiatric Institute on April 20 and 21, the upstate conference in Syracuse on April 27 and May 4. A one-day pathological conference for directors of clinical laboratories and senior pathologists will be conducted at the Psychiatric Institute on April 22. The subjects of the pathological conference also generally concern dementia præcox.

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